MO HealthNet Managed Care
Annual Evaluation

SFY 2008

MO HealthNet Managed Care Annual Evaluation

SFY 2008

Table of Contents

Executive Summary

Introduction

MO HealthNet Managed Care serves members in 54 counties of Missouri, which are divided into three regions: Eastern, Central and Western. MO HealthNet Managed Care contracts are competitively bid and are currently awarded to six MO HealthNet Managed Care health plans. The MO HealthNet Division is required to monitor MO HealthNet Managed Care health plans to ensure compliance with the MO HealthNet Managed Care contracts.

The MO HealthNet Division (MHD) has conducted an Annual Evaluation of the MO HealthNet Managed Care program for the state fiscal year 2008. The evaluation is divided into ten (10) sections: Development, Approval and Monitoring of the Quality Improvement (QI) Program, Population Characteristics, Quality Indicators, Accessibility of Services, Fraud and Abuse, Information Management, Quality Management, Rights and Responsibilities, Utilization Management and Performance Improvement Projects (PIPs). The MO HealthNet Managed Care health plans also submitted work plans for SFY2009.

Information to conduct the annual evaluation was gathered from the MHD internal systems, MO HealthNet Managed Care health plan reports submitted to the MHD, information gathered and provided by the Department of Health and Senior Services (DHSS), information gathered and provided by the Department of Insurance, Financial Institutions and Professional Registration (DIFP) and the 2007 Missouri MO HealthNet Managed Care Program External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Legislative Changes

Effective July 1, 2007 the following changes to the MO HealthNet Managed Care program occurred as a result of passage of House Bill 11 and Senate Bill 577 during Missouri's 94th General Assembly 2007 legislative session:

❖ Effective January 1, 2008, MO HealthNet Managed Care expanded into 17 additional Missouri counties.

❖ Non-emergency medical transportation was made available to uninsured children in category of aid 71 and 72.

❖ Approved rate increases for dentists and physicians.

❖ Durable medical equipment (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and paternal nutrition, wheelchairs and walkers and diabetic supplies and equipment) was added to the comprehensive benefit package.

Development, Approval and Monitoring of the QI Program

Development, Approval and Monitoring of the QI Program was measured by reviewing each MO HealthNet Managed Care health plan's quality and compliance committees, the analysis of their quality improvement process and the overall effectiveness of their quality improvement program including strengths and accomplishments as well as opportunities for improvement.

This information was taken from the MO HealthNet Managed Care health plan Annual Evaluations for SFY2008.

Strengths and Accomplishments
- ❖ All MO HealthNet Managed Care health plans have a variety of oversight committees to monitor and work towards their QI program.
- ❖ Improvement in some measures of the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- ❖ Preventive programs are implemented to educate participants.
- ❖ Established strong partnerships with agencies and organizations to improve the lives of participants.
- ❖ Strengthen partnerships in rural communities to help prevent avoidable out-migration of care.
- ❖ Review of utilization data to identify under and over utilization resulted in opportunity to improve care.
- ❖ Hiring of a dedicated ED case manager to improve safety of care and services for participants who went to the ED.
- ❖ Network development to serve the needs of participants into 17 additional Missouri counties.
- ❖ Routine education with MTM resulted in a decrease of transportation related complaints.
- ❖ Maintained NCQA accreditation of disease management program.
- ❖ Implemented comprehensive and integrated care management models.

Opportunities for Improvement
- ❖ Continue efforts to increase HEDIS and CAHPS scores.
- ❖ Continue efforts to increase network of providers.
- ❖ Decrease ED utilization.
- ❖ Continue development and evaluation of current clinical PIPs.
- ❖ Continue collaboration between the areas within QI and health plan management to ensure interventions to improve service and clinical care is ongoing.

Population Characteristics

Population Characteristics were measured by reviewing each MO HealthNet Managed Care health plan's race/ethnicity, special needs, identified languages, and opt-outs from the MO HealthNet Managed Care health plan annual evaluations for SFY2008. Additionally, the MHD performed region wide analysis measuring the same population characteristics and are noted in this section.

Across all MO HealthNet Managed Care health plans during SFY 2008 the race of enrollees consisted of 57.84% white, 38.02% black, 0.92% Hispanic, 0.58% multi-racial, 0.17% Asian, and 0.13% 'other'. There were also 2.33% of enrollees in which race/ethnicity was undetermined.

Eastern region enrollees consisted of 51.83% black and 44.49% white; Central region enrollees consisted of 12.42% black and 84.16% white; and Western region enrollees consisted of 32.65% black and 62.09% white.

During SFY 2008 there were 11,390 individuals that were identified with special health care needs and were reported to the appropriate MO HealthNet Managed Care health plan. Of these 43.76% were in the Eastern Region, 26.65% were in the Central Region, and 29.68% were in the Western Region.

In all MO HealthNet Managed Care health plans during SFY 2008 there were 53.03% of MO HealthNet Managed Care enrollees whose primary language was English. Additionally, 0.16% enrollees listed Spanish as their primary language, 0.19% other languages and 46.54% of enrollees had no primary language listed. The highest percentage of enrollees in each region who identified having a primary language identified English as their primary language with Spanish being a distant second.

In all MO HealthNet Managed Care health plans during SFY 2008 there were 544 MO HealthNet Managed Care members that chose to opt-out of the MO HealthNet Managed Care program. Of these 89.34% were processed by Policy Studies, Inc. (PSI) and 10.66% were processed by the Participant Services Unit at MHD. Regionally, of all the opt-outs 35.11%were in the Eastern region, 35.11% were in the Central region and 29.78% were in the Western region. There were 473 enrollees in the 1915(b) Waiver and 71 enrollees in the 1115 Waiver in the total opt-out group.

The top five opt-out reasons are:
1. Better Benefits – 38.05%
2. Doctor Takes Straight MO HealthNet – 32.90%
3. Other – 20.77
4. Too Many Doctors – 5.15%
5. No information Provided by PSI – 1.84%

Of the 544 enrollees that chose to opt out, 58.64% opted-out after enrollment into a MO HealthNet Managed Care health plan; 38.42% chose to opt-out prior to enrollment into an MO HealthNet Managed Care health plan; 2.57% re-enrolled into a MO HealthNet Managed Care health plan; and 0.37% indicated 'other'.

Quality Indicators

Quality Indicators were measured by reviewing each MO HealthNet health plan's performance measures, trends in quality indicators, and HEDIS indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births. This information was taken from the MO HealthNet Managed Care health plan Annual Evaluations for SFY2008.

The MHD and DHSS both gather HEDIS information from the MO HealthNet Managed Care health plans on an annual basis. HEDIS is a standardized set of performance measures designed to enable purchasers and consumers to compare the performance of the Managed Care health plans. The HEDIS measures collected by the MHD are compiled into a statewide report to provide information back to the health plans. This enables the health plans to compare their performance to the other health plans and to see how their performance ranks against the statewide average.

Strengths and Accomplishments
- ❖ Identified trends and established corrective action plans.
- ❖ Educated providers in proper documenting in the medical record and accurate coding.
- ❖ Created focus studies and PIP's to further improve quality.

Opportunities for Improvement
- ❖ Not all health plans performed a year-to-year comparison for HEDIS measures.
- ❖ Continue to identify participants for case management, especially those considered high risk.
- ❖ Continue to utilize focus studies and PIPs as tools to improve services to members.

Accessibility of Services

Accessibility of Services was measured by reviewing the health plan's average speed of answer, call abandonment rate, non-routine and routine needs appointments, access to emergent and urgent care, network adequacy and provider/enrollee ratios, 24 hour access and after hours availability, open and closed panels, cultural competency and requests to change practitioners. This information was taken from each MO HealthNet Managed Care health plan's annual evaluations for SFY2008.

Strengths and Accomplishments
- ❖ Conducted workshops dealing with cultural competency to meet the unique and diverse need of all members.
- ❖ Monitoring indicates adequate average speed of answer and call abandonment rate.
- ❖ Monitoring indicates adequate appointment standards and after-hours access to emergent and urgent care.

Opportunities for Improvement
- ❖ Ensure provider directories are current so that members are provided with accurate provider information.
- ❖ Monitor grievance and appeals for accessibility of services issues.
- ❖ Monitor requests to change practitioners for trends in appointment standards, after hour availability, provider and provider staff behavior and other provider related issues.

Additionally, the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) evaluated access plans submitted and received annually by the MO HealthNet Managed Care health plans. The DIFP calculates the enrollee access rate for each type of provider in each county the MO HealthNet Managed Care health plans serve to determine if the average enrollee access rates for each county and the average enrollee access rate for all counties are greater than or equal to ninety percent (90%). The entire MO HealthNet Managed Care population is used in the calculation for each MO HealthNet Managed Care health plan.

Strengths and Accomplishments
- ❖ 2008 Network Analysis completed by the DIFP determined that all MO HealthNet Managed Care health plans met the 90% standard.
- ❖ All health plans achieved 100% in the PCP distance standard per state regulation 20 CSR 400-7.095(3)(A)1.B.

❖ All health plan dentist/enrollee ratios were within the benchmark dentist/enrollee ratios found by the MHD research.

Opportunities for Improvement
❖ Several MO HealthNet Managed Care health plans had a decline in network distance standards from SFY 2007.
❖ While all MO HealthNet Managed Care health plans met the 90% network distance standard, not all health plans achieved 90% in every provider type category. Continued efforts should be made to increase provider access the all provider categories.

Fraud and Abuse

Fraud and Abuse was measured by reviewing each MO HealthNet Managed Care health plan's prevention, detection and investigation practices as well as training and education. This information was taken from the MO HealthNet Managed Care health plan annual evaluations for SFY2008.

Effective beginning in SFY 2006 the MO HealthNet Managed Care health plans began using a uniform reporting system for their quarterly reports to the MHD. When appropriate the MO HealthNet Managed Care health plans report to and cooperate with the Medicaid Fraud Control Unit (MFCU), the Attorney General's Office and other agencies that conduct investigations for the purpose of exchanging information and strategies for addressing fraud and abuse, as well as allowing access to documents and other available information related to program violations.

Strengths and Accomplishments
❖ Screens providers against the Office of Inspector General (OIG) debarred providers and other national lists.
❖ Special committees and units to focus on fraud and abuse.
❖ Coordinates among health plan departments to provide comprehensive prevention, identification and investigation of fraud and abuse.
❖ Special Investigation Units and special committees focused on fraud and abuse.
❖ Continued education to staff, providers and members regarding fraud and abuse.
❖ Initiate and monitor lock-in on members when warranted to reduce fraudulent use of pharmacy benefits and other services.
❖ Claim processing edits to better identify coding irregularities that may indicate fraud and abuse.

Opportunities for Improvement
❖ Identify new enrollees who were locked in to a previous health plan due to fraud and/or abuse.
❖ Fraud and abuse should be reported timely to the MHD and other agencies when appropriate.
❖ Quarterly fraud and abuse reports submitted to the MHD should be accurate and complete.
❖ Monitor member and provider grievance and appeals for trends that may indicate fraud and abuse.
❖ Continue to monitor claim submissions and implement additional edits to better identify potential fraud and abuse.

❖ Continue health plan staff, provider and member training in fraud and abuse prevention and detection.

Information Management

Information Management was measured by reviewing each MO HealthNet Managed Care health plan's claims processing/timeliness of claims payment process, membership and provider enrollment. For this section the MHD used information from the 2007 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Encounter claims data are used by the Missouri Department of Social Services, MO HealthNet Division (MHD) to conduct rate setting and quality improvement evaluation. Before MHD encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) were identified by the MHD and examined by the EQRO for completeness, accuracy, and validity using an extract file from MHD paid encounter claims. To examine the extent to which the MHD encounter claims database was complete (the extent to which MHD encounter claims database represents all claims paid by MO HealthNet Managed Care health plans); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the MHD encounter claims database was examined by comparing data in the MHD encounter claims database to the medical records of members. A random sample of medical records was used to compare the diagnosis codes, procedure codes, drug name dispensed, and drug quantity dispensed in the MHD encounter claims database with documentation in member medical records. The findings of these comparisons were used to determine the completeness of the MHD encounter claims database in regards to the medical records of members. The completeness of the MHD paid encounter claims was then compared with MO HealthNet Managed Care health plan records of paid and unpaid claims. This proved to be a difficult task, as all of the health plan data submissions did not include unique claim identifiers that could be used to accomplish this comparison, this is not a health plan issue, these unique claim identifiers are not available until a claim is of paid status. All six MO HealthNet Managed Care health plans provided data in the format necessary to make the comparisons. This was the first year that all health plans have done this correctly. The results obtained are detailed in the results of the Aggregate Encounter Data Validation section of this report.

Strengths
1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans. The MHD encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.

2. For all MO HealthNet Managed Care health plans, the first Outpatient Diagnosis Code field was 100.0% complete, accurate and valid.

3. All MO HealthNet Managed Care health plans submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the MHD database.

4. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet Managed Care health plans in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by Region or type of MO HealthNet Managed Care health plan.

5. There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.

6. Unpaid claims represent less than .01% of all claims submitted to the MHD.

Areas for Improvement
1. For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the MHD.

2. The Procedure Code field in the Outpatient Home Health and Outpatient Hospital claim types included some invalid information. Most of this was due to blank fields or fields containing "00000".

3. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.

4. The match rates between the MHD database and MO HealthNet Managed Care health plan medical records for claim type procedures were 52.0%, a significant decrease from last year's match rate of 73.24%. Medical records that did not have procedure codes that matched the MHD encounter claims extract file were in error primarily due to missing or incorrect information.

5. The match rates between the MHD database and MO HealthNet Managed Care health plan medical records for claim type diagnoses were 47.0%; this is significantly lower than last year's match rate of 70.56%. Medical records that did not have procedure codes that matched the MHD encounter claims extract file were in error primarily due to missing or incorrect information.
.

Recommendations
1. It is recommended that the MHD institute additional edits for the Medical, Inpatient and Outpatient Hospital claim types to edit claims with blank fields or dummy values (e.g., "000" and "99999999").

2. The MHD should continue to provide timely feedback to MO HealthNet Managed Care health plans regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.

3. Additional analysis on the rate of consistency of services should examine demographic (e.g., age and gender distribution), epidemiological (diagnostic variables), and service delivery (e.g., number of users per month, rate of procedures or claim types, units of service rates) characteristics to explain variation across health plans or Regions.

4. MO HealthNet Managed Care health plans' medical record reviews should be targeted toward validation of diagnosis and procedure codes and/or descriptors.

5. The MHD should clarify the expectations for MO HealthNet Managed Care health plans in the level of completeness, accuracy, and validity and which data fields are required (e.g., Diagnosis Code fields 2 through 5).

6. The MHD should provide timely feedback to MO HealthNet Managed Care health plans when standards are not met and develop corrective action plans when standards are not met within a reasonable amount of time as established by the MHD.

7. The MO HealthNet Managed Care health plans should all investigate the reasons for the much lower match rates between diagnosis and procedures found by the EQRO during the 2007 report versus the rates found in the 2006 report.

Quality Management

Quality Management was measured by reviewing each MO HealthNet Managed Care health plan's provider satisfaction, care coordination, case management, disease management program, mental health care management including case management, clinical practice guidelines, credentialing and re-credentialing, medical record review and subcontractor monitoring. This information was taken from the MO HealthNet Managed Care health plan annual evaluations for SFY2008.

Strengths
  ❖ Provider satisfaction studies generally yielded positive responses.

  ❖ Care management for pregnant women starting early in pregnancy to provide educational information, support and to identify risk factors.

  ❖ Care coordination and case management processes are in place to identify members in need of specialized care.

  ❖ Disease management programs to focus on management of chronic long term conditions in an effort to prevent exacerbations and /or complications related to specific diagnosis.

  ❖ Approved clinical practice guidelines are made applicable to all network physicians and are revised on an as-needed basis.

  ❖ Medical record reviews are used to identify areas for improvement, to develop actions to improve provision of service to members and to improve provider documentation of services.

- ❖ Credentialing and re-credentialing of providers to confirm their qualifications prior to participation and continue once they become part of the health plan's provider network.

- ❖ Subcontractor monitoring is ongoing to ensure the quality of care and quality of services provided on behalf of the health plan is in compliance with all requirements of their contract with the MHD. Corrective action plans are implemented and monitored when warranted.

Areas for Improvement
- ❖ Quality management encompasses a variety of opportunities to provide quality services to members. Health plans should continue to strive to identify, improve and accurately document all aspects relating to the quality of care and oversight to members and network providers.

Rights and Responsibilities

Rights and Responsibilities were measured by reviewing each MO HealthNet Managed Care health plan's member grievance and appeals, and provider complaint, grievance, and appeals, and member confidentiality practices.

The MHD used quarterly reports submitted by the MO HealthNet Managed Care health plans regarding member grievances and appeals, provider complaints, grievances and appeals, and information taken from each MO HealthNet Managed Care health plan's annual evaluations. Beginning January 1, 2006 all health plans were required to use a standardized database for reporting member grievances and appeals, and provider complaint, grievances, and appeals.

Strengths
- ❖ All MO HealthNet Managed Care health plans report member grievances and appeals and provider complaints, grievances and appeals via the required database on a quarterly basis.

- ❖ Reported member grievance and appeals were less than 1 per 100 members in SFY2008 across all health plans, with the exception of transportation issues which was less than 3.0 per 100 members.

- ❖ Reported provider grievance and appeals were less than 1 per 1000 members in SFY2008 across all health plans with the exception of provider grievances – claim denial, which were less than 1.5 per 1000.

- ❖ Reported provider complaints measured as high as 16.8 per 1000 members for claim denial and 3.2 per 1000 for service denials in SFY 2008. The majority of other complaint categories fell below 1 per 1000 members.

- ❖ Health plans have written policies and procedures regarding member rights which comply with State and Federal regulations.

Areas for Improvement
- ❖ Ensure all member grievances and appeals, and provider complaints, grievances and appeals are recorded and submitted to the MHD on the quarterly reports. This must include issues received from MHD, state fair hearing requests and from all other sources with a complaint, grievance or appeal pertaining to, or on behalf of, a member or provider.

- ❖ Increase education to transportation subcontractors and providers in an effort to reduce the number of complaints, grievances and appeals in those areas.

Utilization management

Utilization Management was measured by reviewing each MO HealthNet Managed Care health plan's utilization improvement program scope including discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery and timeliness of prior authorization/certification decision making. This information was taken from the MO HealthNet Managed Care health plan annual evaluations for SFY2008.

Strengths
- ❖ A large scope of utilization management processes continuously monitor discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery, and timeliness of prior authorization/certification decision making.

Areas for Improvement
- ❖ Continue to monitor utilization patterns and implement processes as warranted by the patterns identified.

Performance Improvement Projects (PIPs)

Performance Improvement Projects were measured by reviewing clinical and non-clinical PIPs, as well as on-going interventions and improvements. For this section the MHD used information from the 2007 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MO HealthNet Managed Care health plan that were underway during 2007. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the health plans, MHD, and the EQRO. The final selection of the PIPs for the 2007 validation process was made by the MHD in December 2007. PIPs are to be aimed at studying the effectiveness of clinical or non-clinical interventions, and should improve processes highly associated with healthcare outcomes, and/or healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for MO HealthNet Managed Care, health plans are required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical

assistance was provided to each health plan by the EQRO during the site visits for improving study methods, data collection, and analysis.

Access to Care
Access to care was an important theme addressed throughout all the PIP submissions reviewed. Five of the PIPs utilized enhanced case management procedures to ensure that members had access to care, were reminded of appointments, and that case managers were available to ensure that barriers to services were decreased. Two health plans focused on education and support to obtain appropriate services and medications for the treatment of asthma and access to lead screening (Missouri Care and Harmony Health Plan). All the projects reviewed used the format of the PIP to improve access to care for members. Three of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (HealthCare USA, Missouri Care, BA+). The on-site discussions with health plan staff indicate the realization that improving access to care is an ongoing aspect of all projects that are developed. One health plan (Mercy CarePlus), developed an ongoing PIP into a project that provides case management services to all pregnant members. As outcome data are finalized, and as an example of both improved access and quality of care, this project should become a best practice to be shared throughout the health plans.

Quality of Care
Topic identification was an area that provided evidence of the attention placed on providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. All PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the health plan, or in the direct provision of services delivered. The corresponding interventions that address barriers to quality care and health outcomes were clearly evident in the narratives submitted. There was further evidence of a commitment to quality of care during on-site discussion at each health plan, including the desire to supply supplemental and updated information to ensure that project efforts and outcomes were clearly reported. These interventions addressed key aspects of enrollee care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

Timeliness of Care
Timeliness of care was the major focus of a number of the PIPs reviewed. Three projects identified the need for timely aftercare for members who required inpatient hospitalization for mental illness (HealthCare USA, Missouri Care, and BA+). The remaining projects focused on subjects such as timely processing and resolution of grievances and appeals (HealthCare USA, and BA+), appropriate medications and treatment for asthma (Missouri Care), improved access to non emergent transportation services (Children's Mercy Family Health Partners), improved access to well-child visits in the first 15 months of life (Children's Mercy Family Health Partners). All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

Recommendations
1. It is recommended that health plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. One health plan (Children's Mercy Family Health Partners) continues to utilize the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, the health plans need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each health plan as a guideline to frame the development, reporting and analysis of the PIP
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.
4. PIP's that are not yet complete should include narrative reflecting next steps and a plan for how the PIP will be maintained and enhanced for future years.
5. It appears that in most instances the health plans conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations' ability to serve members is beneficial.

Conclusion

Review of the SFY 2008 Annual Evaluations submitted by the MO HealthNet Managed Care health plans reveal areas in which improvement is evident as well as declines in measures from SFY2007. MO HealthNet Managed Care health plans need to continue existing processes for continued improvement and implement new processes and evaluations as warranted.

MO HealthNet Managed care health plans should only include in their annual evaluation processes and achievements relating to MO HealthNet and not what they have accomplished in other states and/or commercial lines. Health plans must also adhere to the required format and submit required data when submitting their annual evaluation.

The MO HealthNet Managed Care health plans have submitted detailed work plans for the next year which outline their continued efforts in providing quality health care to participants in MO HealthNet Managed Care while maintaining compliance with their contract with the MHD.

Annual Enrollment Analysis

Enrollment
On July 1, 2007, the start of State Fiscal Year 2008 (SFY2008), there were 344,799 individuals enrolled in MO HealthNet Managed Care compared to 381,935 individuals enrolled at the end of SFY 2008 (June 30, 2008). Enrollment in MO HealthNet Managed Care increased by 37,136 individuals during SFY2008 mainly due to the expansion of MO HealthNet Managed Care into 17 additional counties on January 1, 2008. Statewide there were 833,112 participants enrolled in the MO HealthNet Program as of June 30, 2008. MO HealthNet Managed Care enrollees accounted for 45.8% of the total enrollment.

At the end of SFY2008 there were 188,834 enrollees (49.4%) in the Eastern region, 72,736 enrollees (19.0%) in the Central region, and 120,365 enrollees (31.5%) in the Western region. Individuals eligible for coverage under the 1915(b) Waiver accounted for 345,868 (90.6%) of the enrollees and 36,067 individuals (9.4%) were eligible under the State Children's Health Insurance Program.

Enrollment in the MO HealthNet Managed Care Program increased in all three MO HealthNet Managed Care regions during SFY2008. On January 1, 2008, 17 counties were added to the MO HealthNet Managed Care regions.

The following three counties were added to the Eastern Region: Pike, Perry, and Madison.

The following ten counties were added to the Central Region: Linn, Macon, Shelby, Marion, Ralls, Benton, Laclede, Pulaski, Maries, and Phelps.

The following four counties were added to the Western Region: Bates, Vernon, Cedar, and Polk.

Please refer to attachments 1 through 6.

Auto-Assignments
During SFY2008 126,983 enrollees (33.2%) were auto-assigned to MO HealthNet Managed Care health plans. Of these, 102,165 (80.5%) were eligible for coverage under the 1915(b) Waiver and 24,818 (19.5%) were eligible under SCHIP. There were 43,732 enrollees auto-assigned in the Eastern region, 38,700 in the Central region and 44,521 in the Western region during the period July 2007 through June 2008. HealthCare USA in the Eastern region received the majority of the random auto-assignments (12.7%) while Molina Healthcare in the Central region received the least amount of the random auto-assignments (2.2%).

Please refer to attachments 7 through 9.

Member Selection
Statewide approximately 104,708 members selected a MO HealthNet Managed Care health plan during SFY2008. Of those members selecting an MO HealthNet Managed Care health plan, 42,076 (40.2%) were in the Eastern region, 29,770 (28.4%) were in the Central region, and 32,862 (31.4%) selections were in the Western region.

Individuals eligible for coverage under the 1915(b) Waiver accounted for 80,765 of the selections and 23,943 SCHIP members selected their own MO HealthNet Managed Care health plan.

The majority of members selected HealthCare USA (24,165) in the Eastern region, HealthCare USA (16,225) in the Central region, and Family Health Partners (14,644) in the Western region. Molina Healthcare in the Central region experienced the lowest number of member selections (4,942).

Please refer to attachments 7 through 9.

Transfers
There were 28,294 individuals statewide that transferred between MO HealthNet Managed Care health plans during SFY2008. Of these, 11,347 individuals (40.1%) transferred in the Eastern region, 8,178 (28.9%) in the Central region, and 8,769 individuals (31.0%) in the Western region.

During SFY2008, there were 22,607 individuals eligible for coverage under the 1915(b) Waiver and 5,687 individuals eligible for coverage under SCHIP that transferred between MO HealthNet Managed Care health plans.

Please refer to attachments 10 and 11.

Supplemental Security Income (SSI) Opt-Outs
In all MO HealthNet Managed Care health plans during SFY2008 there were 544 MO HealthNet Managed Care members that chose to opt-out of the MO HealthNet Managed Care program. Of these 89.34% were processed by Policy Studies, Inc. (PSI) and 10.66% were processed by the participant services unit at MHD. Regionally, of all the opt-outs 35.11% were in the Eastern region, 35.11% were in the Central region and 29.78% were in the Western region. There were 473 enrollees in the 1915(b) Waiver and 71 enrollees in the 1115 Waiver in the total opt-out group.

The top five opt-out reasons are:
1. Better Benefits – 38.05%
2. Doctor Takes Straight MO HealthNet – 32.90%
3. Other – 20.77
4. Too Many Doctors – 5.15%
5. No information Provided by PSI – 1.84%

Of the 544 enrollees that chose to opt out, 58.64% opted-out after enrollment into a MO HealthNet Managed Care health plan; 38.42% chose to opt-out prior to enrollment into an MO HealthNet Managed Care health plan; 2.57% re-enrolled into a MO HealthNet Managed Care health plan; and 0.37% indicated 'other'.

Please refer to attachment 12.

Special Health Care Needs
During SFY2008 there were 11,390 individuals that were identified with special health care needs and were reported to the appropriate MO HealthNet Managed Care health plan. Of these 43.76% were in the Eastern Region, 26.65% were in the Central Region, and 29.68% were in the Western Region.

Please refer to attachment 13.

Race
Across all MO HealthNet Managed Care health plans during SFY2008 the race of enrollees consisted of 57.84% white, 38.02% black, 0.92% Hispanic, 0.58% multi-racial, 0.17% Asian, and 0.13% 'other'. There were also 2.33% of enrollees in which race/ethnicity was undetermined.

Eastern region enrollees consisted of 51.83% black and 44.49% white; Central region enrollees consisted of 12.42% black and 84.16% white; and Western region enrollees consisted of 32.65% black and 62.09% white.

Please refer to attachment 14.

Languages Identified
In all MO HealthNet Managed Care health plans during SFY2008 there were 53.03% of MO HealthNet Managed Care enrollees whose primary language was English. Additionally, 0.16% enrollees listed Spanish as their primary language, 0.19% other languages and 46.54% of enrollees had no primary language listed. The highest percentage of enrollees in each region who identified having a primary language identified English as their primary language with Spanish being a distant second.

Please refer to attachment 15.

This page intentionally left blank

Development, Approval and Monitoring of the Quality Improvement Program

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Quality and Compliance Committee
BCBSKC has an integrated quality and compliance system for its managed care programs. Under the direction of the governing bodies for each managed care program, the Quality Council is the internal committee responsible for day-to-day operations of the quality assessment and improvement program, and for approving recommendations made by other committees relative to the Quality Improvement Program. Other important quality management and compliance-related committees include the Delegated Oversight Committee, joint BCBSKC/New Directions Delegated Oversight Committee, Medical and Pharmacy Management Committee, Care Connections Advisory Council, Peer Review Committee, and the BA+ Oversight Committee. These committees meet regularly to evaluate performance toward meeting goals, and to address quality concerns. Minutes and other appropriate documentation are available for each of these Committees.

The roles, functions, and responsibilities of each Committee within BCBSKC are included in the Quality Improvement System Description and Committee Charter. The committee chair is responsible for reporting and functioning of the Committee. The roles, functions and responsibilities of the Medical Director are clearly defined in the job description and the Quality Improvement System Description.

The Compliance Committee is chaired by the Director, Audit Services and Compliance Officer. The Committee meets monthly to address compliance issues. The Compliance Committee acts on reports of oversight activities from the Delegated Oversight Committee, the joint BCBSKC/New Directions Behavioral Health Delegated Oversight Committee, and the BA+ Oversight Committee. Minutes and other appropriate documentation are available.

Analysis of Quality Improvement Process
NCQA Accreditation –BCBSKC is accredited by the National Committee for Quality Assurance (NCQA) for certain of its health Plans and programs. BCBSKC renewed its accreditation status of "Excellent", the highest level possible, for its commercial HMO product, Blue-Care, by the National Committee for Quality Assurance (NCQA) in 2008. The company's Preferred-Care Blue PPO product also renewed its accreditation, receiving "Full" accreditation, the highest level awarded for PPO products by NCQA.

BCBSKC is also accredited by URAC for several programs, including Health Provider Credentialing (including the BA+ network), and Health Utilization Management.

Accreditation has been found to be associated with industry best practices. Accredited companies are more likely to measure and report quality performance.

BCBSKC's corporate policies and procedures, and quality assessment and improvement program structure, are designed to meet or exceed NCQA and URAC's standards. This infrastructure also supports BA+'s QA&I activities, ensuring that BA+ members and providers, and the State of Missouri benefit from gains in managing administrative costs and improving service and quality of healthcare that are realized from the BCBSKC Quality Improvement Program. Achieving the highest level of quality is clearly the expectation of the BCBSKC organization.

While the State of Missouri does not require NCQA or URAC Accreditation, there is a significant benefit to the member, provider, and State for a Plan that achieves these accreditations. The benefit to the MO HealthNet member, provider, and the State is the development of the policies and processes adopted which provides a springboard to make quality member-centered decisions for the MO HealthNet program, taking into account the differences in the MO HealthNet program. The level of quality achieved by benchmarking against NCQA and URAC Accreditation has become a standard for BCBSKC through all of our programs, including BA+. The State and the member benefit from being a part of an organization that has attained such a distinction. The State and members are getting a quality provider of services when they see BCBSKC is NCQA and URAC accredited.

Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments
BCBSKC earned second place among all Blue Plans in Member Touchpoint Measures (MTM) scores with 99.3 points in the fourth quarter of 2007. Earlier in 2007, we placed third and fourth among the Plans. Each of the ten MTM Direct Measures within the 100 point MTM index is scored separately and the scores are summed to yield the total score. The combined score is the measure of overall operational performance. BCBSKC ended the year with an average for 2007 of 97.8, favorable to the corporate goal of 95.3 points.

MTM also provides the majority of the key performance measurements used to evaluate the effectiveness of the service quality improvement program and to drive service improvement efforts. In 2007, eight MTM and two non-MTM measures are the primary means of quantitative evaluation of BCBSKC's performance in the "vital few" areas of operations performance for 2007. These measures evaluate performance in the key process areas of member and group enrollment; claims operations; and customer service operations.

Service performance met or exceeded goal levels on a consistent basis in eight of the ten service performance measures: group-level accuracy; member-level enrollment accuracy; claims processing accuracy; claims processing (dollar) accuracy; claims timeliness; telephone blockage rate; and telephone abandon rate.

Only two of the ten performance measures did not meet 2007 goals. The first, inquiry accuracy, averaged a rate of 98.5 percent, slightly below the goal of 99 percent, and virtually unchanged since 2005. The second, inquiry timeliness, was 94.6 percent, which is an improvement over 2005 and 2006 but does not meet the new, higher, goal of 95 percent set for 2007.

During 2007, BCBSKC launched CareConnection, a comprehensive and integrated care management model. Members in vendor-managed disease management programs were transitioned to in-house programs and expanded to include Blue-Advantage Plus members.

Bringing these programs in-house made it possible to extend the program and offer members the support of a registered dietitian, health coaches and one-on-one RN care managers. CareConnection utilizes new healthcare management and analytic tools, launched in 2007 – CareAdvance (a TriZetto product), and a new financial/utilization analytical tool, BlueReports.

Also in 2007, BCBSKC had improvement in HEDIS "Effectiveness of Care" results. For seven measures, more than any other Kansas City health Plan, BCBSKC's health Plans were the "Best in Kansas City:" These "Best in Kansas City" rates included:

☐ Diabetes – comprehensive eye exam (also "Best in Kansas City" in 2006);

☐ Advising smokers to quit (also "Best in Kansas City" in 2006);

☐ Cervical cancer screening (also "Best in Kansas City" in 2006);

☐ Childhood immunizations (also "Best in Kansas City" in 2006);

☐ Follow-up ambulatory visit within seven days after hospitalization for mental health diagnosis;

☐ Breast cancer screening; and

☐ Beta blocker after myocardial infarction (heart attack).

BCBSKC trends performance year-over-year for important clinical measures, ensuring that there is continued improvement in clinical outcomes. Those measures that showed improved performance and/or performance at the benchmark of NCQA's 90th percentile included:

☐ Diabetes – screening for nephropathy, and AIC control;

☐ Persistence of beta blocker after myocardial infarction (heart attack);

☐ Asthma – appropriate management.; and

☐ Cholesterol management after cardiac event.

☐ Clinical measures where improvement is still needed included:

☐ Diabetes – dilated eye exam;

☐ Diabetes – A1C tests; and

☐ Diabetes – LDL tests.

Opportunities for Improvement
Due to the distributed nature and number of performance improvement activities across the company, continued strong collaboration between the areas of Quality Management, Operations Support Services, Operations Performance Improvement, Population Management and Care Management is needed to ensure that strong interventions to improve service and clinical care

are ongoing, meaningful to the population, and measured and documented in a way that is acceptable to BCBSKC leadership and external reviewers. Meaningful integration of the quality improvement program goals with those of the corporate business plan will continue to focus on the following broad areas: improving the quality of health outcomes, decreasing healthcare costs, and improving service.

Children's Mercy Family Health Partners

The annual Quality Program evaluation process is overseen by the Chief Clinical Officer. Involvement from multiple areas within Children's Mercy Family Health Partners (CMFHP) is necessary to ensure comprehensive evaluation and review of the documents.

Evaluation of the key performance measures and progress toward goals established is an ongoing process that takes place in multiple forums within CMFHP, including the weekly Administrative Oversight Committee, the monthly Health Services Review Committee, the quarterly Medical Management Committee, and the semiannual Medical Oversight Committee. The annual evaluation looks at the past year of information collected and actions taken and evaluates progress toward established goals, as well as determines areas for improvement in the upcoming year.

The Medical Director provides an overview of the annual evaluation to the Medical Oversight Committee. The Chief Executive Officer of Children's Mercy Family Health Partners reviews the annual evaluation documents and provides an overview to the Board of Directors.

Quality and Compliance Committee
The Children's Mercy Family Health Partners (CMFHP) Board of Directors has ultimate authority and responsibility for oversight of the Quality Management Program.

1. Quality Management activities are reported as requested to the Board of Directors by a Medical Director or appropriate staff. Credentialing material is reported quarterly by a Medical Director or appropriate staff.
2. The Medical Oversight Committee (MOC) approves the Quality Management Plan and substantive modifications to the plan.

The MOC has the authority and responsibility to direct the development and implementation of the internal Quality Management Plan, provide overall direction in matters of medical management and monitor the quality of care that CMFHP members receive. The committee meets semiannually to provide program oversight.

The MOC does oversight of the Health Services Committees, Medical Management Committee and Quality Management Committee, which includes the subcommittees that report to them. In addition, the MOC reviews annual work plans, audit results, physician satisfaction surveys, risk management issues and activities of subcommittees. MOC

completes quarterly review of clinical care, quality of service, UM reports, provider and pharmacy profile reports, service standards and other quality improvement activities.

See the attached updated Children's Mercy Family Health Partners Medical Committee Organizational Chart.

2008 CMFHP Medical Committee
Organizational Structure

Green = Internal Committee
Blue = External Committee

CMFHP Board of Directors

Medical Oversight Committee* (MOC)
MO and KS
Chair: Dr. Liz Peterson

Medical Management Committee (MMC)
MO and KS
Chair: Dr. Liz Peterson

Quality Management Committee (QMC)
MO and KS
Chair: Dr. Brenda Rogers

Mental Health Committee
New Directions
MO only
Chair: Ma'ata Touslee

Dental Committee
Bridgeport
MO only
Chair: Sharon Traylor

Nurse Advice Committee
McKesson and CMH
MO and KS
Chair: Lisa Gabel

Health Services Review Committee
MO and KS
Chair: Ma'ata Touslee

Pharmacy and Therapeutics Committee (P&T)
KS only
Chair: Elizabeth Schmitz, PharmD

Credentialing Committee
MO and KS
Chair: Dr. Uri S. Alon

Disease Management Committee
MO and KS
Chair: Greg Hanley

Health Improvement Committee
MO and KS
Chair: Greg Hanley

Clinical Criteria Committee
MO and KS
Chair: Dr. Liz Peterson

Psychiatric Drug Committee (PDC)
KS only
Chair: Elizabeth Schmitz, PharmD

HEDIS Committee
MO and KS
Chair: Jenny Hainey

*MOC reports to the CMFHP Board of Directors through the CMFHP CEO

Analysis of Quality Improvement Process
During 2007 and 2008, Children's Mercy Family Health Partners (CMFHP) continued efforts to increase communication and collaboration with both external and internal stakeholders.

Throughout the year, CMFHP continued incorporating all departments in the Performance Improvement process. Staff routinely received information regarding Key Performance Indicators and Performance Improvement projects through various avenues, including: monthly all staff meetings, Administrative Oversight Committee meetings, monthly newsletters, quarterly Medical and Quality Management Committee meetings, and Semiannual Medical Oversight Committee meetings.

In addition, CMFHP continued to put significant effort into oversight and collaboration with subcontracted vendors, specifically Bridgeport Dental, New Directions Behavioral Health, and MTM Transportation. Through quarterly oversight meetings, data review and discussion

occurred to help facilitate performance improvement projects, improve reporting of key indicators, and monitoring of health plan performance indicators.

Overall Effectiveness of the Quality Improvement Program
    Strengths and Accomplishments
    Opportunities for Improvement

Preventive Programs

Children's Mercy Family Health Partners supports and facilitates preventive programs and services for its members whenever possible. In 2007-2008, CMFHP's preventive programs and services included:

- Asthma disease management program
- HeLP (Healthy Lifestyles) PCP and member education program
- Education on immunizations for children and adolescents
- Education on well care visits to children and adolescents
- Education on nutrition and exercise through a Food Power Program
- Education on postpartum depression to members post delivery
- Notification to members with no claims history of Primary Care Provider visits
- Increasing access to Primary Care Providers through ER Case Management initiative
- Well-woman outreach
- Well-man outreach
- Education on cervical cancer screenings
- Education on STD/Chlamydia screenings
- Education on dental screenings among children and adolescents
- Breast cancer screening outreach
- Lead screening outreach

Harmony Health Plan of Missouri

Harmony's response to the Development, Approval and Monitoring of the QI program did not follow the format required by the contract nor contains the information requested.

HealthCare USA

Quality and Compliance Committee
The Quality Management Committee (QMC) is delegated by the governing body and administration to prioritize and coordinate all organization wide quality and utilization/performance improvement activities in accordance with the approved Quality Improvement Program Strategy. In addition to the Board of Managers, a review of and recommendations related to quality improvement activities are received from the Executive

Quality Committee, the Physician Advisory Council and other departments and committees of HealthCare USA.

The QMC is comprised of HealthCare USA leaders, the Medical Director, and at least five network physicians, credentialed by either HealthCare USA or a delegated entity. The Medical Director, Vice President of Health Services, provider relations and other physicians recommend physicians from the community for participation on the committee. The Medical Director, serving as the chairperson, makes final selection decisions.

The QMC meets at least quarterly, or more often at the call of the Chair. Business is conducted by written agenda, which is maintained on file with the minutes of each meeting.

The QMC oversees the quality and utilization/performance improvement function organization wide, as well as all key processes associated with successful implementation and outcomes. Specifically, the QMC shall:

- Develop, modify, and approve the Quality Improvement Program Strategy prior to approval by the Board of Managers.

- Approve quality and utilization management initiatives based on organization strategic priorities, the QI strategic plan and available resources.

- Prioritize quality and utilization management initiatives and other quality improvement projects based on actual or potential impact on improving outcomes of care and service, increasing membership and decreasing costs and, as available, review of data, as well as organization priorities and objectives.

- Oversee and support cross-functional, interdisciplinary teams; facilitate the involvement of various settings, departments, and/or services in support of team activities.

- Contribute to the plan and design of organizational mechanisms and methodologies to support cross-functional, interdisciplinary quality and utilization management/performance improvement activities.

- Review aggregated data/information feedback from customer satisfaction surveys, utilization management processes, adverse/sentinel events, and other data/information impacting organizational performance.

- Review periodic data and outcome summaries from quality and utilization performance improvement initiatives.

- Oversee a confidential peer review process whereby all practitioner-specific issues are referred to the appropriate peer review committee or manager.

- Determine and support the education and training needs of the organization related to quality and utilization performance improvement.

- Evaluate the effectiveness of the quality and utilization/performance improvement activities of the departments.

- Provide timely summary information concerning improvements in organization performance to all involved.

Compliance Management Committee

Regulatory Compliance staff report all activities, policies, and compliance updates and issues to the Compliance Management Committee (CMC). The Chief Operating Officer (COO) serves as HealthCare USA's Compliance Officer and the Manager of Regulatory Compliance chairs the CMC and is responsible for the plan's overall compliance with applicable Federal, State, and regulatory bodies' standards and regulations. A Regulatory Compliance Analyst co-chair the CMC and acts as the plan's key contact for monitoring and maintaining policies and procedures and marketing distributions, tracking annual approval of these documents, as well as state submissions. The CMC reports directly to the Board of Managers.

Within these positions, maintaining and monitoring Health Insurance Portability and Accountability Act (HIPAA) compliance and managing business associate agreements with physician consultants, other subcontractors, and vendors is administered. Regulatory Compliance staff monitor and maintain the MO HealthNet fraud and abuse program as described in the fraud and abuse policies and procedures. All fraud and abuse cases, as well as coordination, prevention and detection activities, are reported quarterly to the CMC and annually to the State agency. All functions within the Regulatory Compliance department are incorporated into the health plan's Compliance Plan. This Plan adheres to the seven elements of a Compliance Plan, consistent with the Office of Inspector General (OIG) compliance elements.

Education for all compliance standards is provided to employees, members and providers via a variety of different avenues in order to ensure understanding. Education is key to administering compliance and lessening deficiencies. Regulatory Compliance staff conduct internal audits to ensure compliance with all applicable regulations and requirements, including but not limited to the code of federal regulations (CFRs), the code of state regulations (CSRs), HIPAA requirements and the deficit reduction act (DRA). All findings are presented to the CMC to aid in setting compliance standards, the identification of vulnerable areas and associating risk (low, medium, or high) and to monitor ongoing compliance accordingly. The CMC is responsible for initiating corrective action plans as deficiencies are detected.

The CMC reports summary activities at least annually to the Quality Management Committee, the Executive Quality Committee, and at least annually to the Board of Managers. Annually, the CMC evaluates the impact of the Compliance Plan using audit results and oversight information. This information is presented to and approved by the Quality Management Committee (QMC), as delegated by the Board of Managers.

Executive Quality Committee & Physician Advisory Council

HealthCare USA developed an Executive Quality Committee and a Physician Advisory Council (PAC) in 2007. The Executive Quality Committee reviews, makes recommendations, and approves the activities of the Quality Management Committee, the Credentialing Committee, Peer Review Committee, Complaints, Grievances and Appeals Committee, and the Compliance Management Committee, including non-clinical issues related to regulatory compliance, corporate compliance and fraud and abuse. The Committee meets at least quarterly and includes

members of senior leadership and the Senior Executive. The committee is responsible for reviewing the activities and providing feedback to the individual Committees.

The purpose of the PAC is to provide advice and guidance in areas such as physician services, plan activities affecting physician providers in the community, medical and pharmacy management and specialty programs. The Medical Director(s) appoints at least eleven (11) community physician members to reflect a balance of viewpoints, education and experience representing physician practice in rural areas, underserved and urban areas. The PAC meets at least bi-annually and reports to the QMC.

Analysis of Quality Improvement Process
HealthCare USA implemented, in 2007, the rapid cycle methodology to identify, prioritize and accelerate the improvement process and keep focused on targeted improvements. This methodology identifies, implements and measures change to processes. This methodology is flexible in the ability to incorporate lean, six sigma and other performance improvement tools and methods. With the rapid cycle methodology, an overall project goal is defined with specific process and outcome measures. Improvements occur through small rapid PDSA (Plan, Do, Study and Act) cycles or tests of change identified and implemented by a multi-disciplinary team. Decisions to expand, revise or stop a test of change are based on review of data collected, analyzed and reviewed at team meetings.

The PDSA cycle of change involves four steps. A <u>Plan</u> for a test of change is set based on theory and best practice. <u>Do</u>, on a small scale, a test to determine effectiveness without wasting resources. <u>Study</u> the outcomes of the small scale implementation and <u>Act</u> by applying the change to a larger population, stopping the change or revising the change. Outcomes of small tests of change can be seen in real time or a nearly immediate basis, which allows numerous cycles of tests of change to occur in a short period of time. There are often several PDSA cycles for each improvement project implemented.

This quality improvement process has allowed HealthCare USA to more efficiently manage, evaluate and track clinical and operational quality improvement projects. The On-going education and evaluation of the program helps HealthCare USA improve and maintain best practices consistent with evidenced based clinical practice guidelines and national quality improvement standards.

Overall Effectiveness of the Quality Improvement Program
HealthCare USA's Quality Improvement Programs have been effective in meeting and exceeding many of the goals set for individual quality projects and organizational objectives. Through the analysis and evaluation of past outcomes and current data, the plan has been able to implement multiple improvement projects, workgroups and task forces to improve outcomes of care and service, safety, and satisfaction across all three (3) regions of Missouri.

HealthCare USA continues to meet the needs of our diverse membership, expanded services and established strong partnerships with agencies and organizations dedicated to improving the lives of the general population, minority cultures and disparate populations in Missouri. HealthCare

USA continues to strengthen partnerships in rural communities to help prevent avoidable out-migration of care and provide the best services for this population.

The EPSDT workgroup was expanded to include HEDIS measures in 2006. In 2007 and 2008, additional improvements were implemented to focus resources and coordinate efforts across functional areas of the organization. Changes implemented with a multi-disciplinary team reduced duplication of efforts and focused resources, resulting in implementation of many interventions and an overall improvement in measures from calendar year 2007, without an increase in resource utilization. The most significant improvements were seen in asthma medications, adolescent well care, and follow up visits after mental health hospitalizations. HealthCare USA will continue this approach to further improve EPSDT, HEDIS and CAHPS rates in 2009.

HealthCare USA 2008 CAHPS member satisfaction survey rates continued to improve in most areas as compared to previous years. The results for Health Plan Overall for Eastern and Central regions were significantly above the 2007 MO HealthNet average. The Western region's rates improved from 2007 as well. The Health Care Overall rate significantly improved in the Western region for 2008. HealthCare USA will continue to strive to meet and exceed the needs of the membership and improve satisfaction with the Plan.

The HealthCare USA provider network has remained appropriate for the membership. HealthCare USA members had 100 percent access to Primary Care Providers in Central, Eastern, and Western regions in Missouri. The appointment availability and after hours access study revealed appropriate access. Results of surveys and audits are used by the Provider Relations Department to educate providers identified as not adherent to the standards individually and through newsletters and the provider web site with for all providers.

HealthCare USA continues to support a robust Fraud and Abuse Program. A "lunch-n-learn" staff education program was provided and periodic updates and reminders have been in the newsletters and other employee communications

HealthCare USA maintains a focus on ensuring effective and efficient processing of data in the claims, membership, and provider software systems. Data tracking and reporting for each of these areas continue to meet or exceed company standards. HealthCare USA continues to assess processes to identify opportunities and implement activities to improve information systems. Before and after the state encounter amnesty period HealthCare USA continues the encounter data submission performance improvement project to continuously improve completeness and accuracy of encounter data.

Overall provider satisfaction with HealthCare USA and the Customer Service Department has steadily improved over the past few years. HealthCare USA conducted provider seminars in 2006 and 2007, to improve communication and collaboration with providers in each region. Physician Management Advisory Councils (PMAC) meet routinely for on-going provider education, to help increase provider office staff knowledge about new programs, processes and projects, as a forum for provider office staff to identify and discuss barriers and challenges they

are encountering, and to make suggestions for improvements in our programs, processes and projects.

Within Health Services, opportunities to improve clinical, functional, cost, safety and satisfaction outcomes through utilization management, case management and disease management programs were identified. Changes, resulting in improvements and additional opportunities, have been implemented.

To improve communication, coordination, consistency, and on-going education, daily in-patient rounds, combined case management and disease management rounds twice a week, and grand rounds with the Medical Directors, Concurrent Review, Case and Disease Management staff were implemented. An opportunity to improve these same functions with behavioral health was identified and staff from MHNet were added to the daily in-patient rounds and Case and Disease Management rounds. After a trial with phone conferencing, an MHNet behavioral health specialist moved to co-locate with HealthCare USA Care Management staff. An MSW dedicated to assisting with social issues that impact medical outcomes was hired. Routine care management rounds with one of the high volume FQHCs have also been started.

Health Services staff continue to asses the needs of members identified by the state health risk assessment and refer to appropriate services within the Plan. In addition, a standardized process for adult and child health risk assessments was implemented using a national vendor, NRC. Data from the NRC health risk assessments is transferred to the Coventry Claims Data Warehouse (CDW), where individual member reports indicating elevated risk levels are generated and transferred to appropriate resource. Diagnosis specific clinical and functional health risk and member defined needs assessments have been implemented for the High Risk OB and Asthma Disease Management programs.

Review of utilization data, including hospital readmissions, emergency department (ED), primary care, immunizations, and medication fills, to identify under and over utilization resulted in identification of an opportunity to improve care for NICU graduates and members with sickle cell disease. On-going review of ED utilization data and performance improvement team work identified use of dedicated ED case management as an intervention to reduce avoidable, non-emergent ED use.

A dedicated ED Case Manager was hired. ED Case Management was implemented to improve safety of care and services for members who went to the ED. Project interventions include making outbound calls to those who went to the ED to educate about appropriate use of the ED, knowledge of their PCP, importance of the medical home, to verify understanding of ED instructions given and assist with elimination of barriers to adherence with ED follow up instructions.

A pilot program for NICU graduates was implemented in October of this year. A Sickle Cell Disease Management program is in the early stages of development in collaboration with Washington University physicians and St. Louis Children's Hospital Sickle Cell Disease Clinic.

After a pilot test of outbound calls for medication refills to members without claims for routine medications, the Asthma Disease Management program and Diabetes program were expanded to include monthly medication review and outbound calls to those without evidence of a timely refill for routine medications.

In addition to improving communication, coordination and collaboration with HealthCare USA clinical staff, MHNet continued to focus improvement efforts on ambulatory care and family therapy for children and adolescents. MHNet has an ongoing ambulatory follow-up performance improvement project (PIP) to address the needs of patients following discharge for a mental health illness. HEDIS 2008 data analysis shows significant improvement in response to MHNet's PIP. Rates of Follow-Up After Hospitalization for a Mental Illness improved in all three regions, with rates for 30 days and 7 days improving a statistically significant amount in the Central region. Another project has been implemented with several strategies to encourage and improve coordination of care between the PCP and mental health providers, focusing on members receiving family therapy for children and adolescents and members receiving pharmacotherapeutic interventions for behavioral health diagnoses.

The Quality Management Committee has reviewed and approved 30 evidence based clinical practice guidelines (CPGs) in 2006 and 2007. A list and summary of the content of the guidelines are available on the HealthCare USA provider website. Direction about how to obtain written copies of complete CPGs electronically and in writing are included on the website, in denial letters and periodically in the newsletters, and in new provider packets.

The updated asthma evidence-based clinical practice guidelines, released in 2007, were adopted by the QMC and are incorporated as the basis of the Asthma Disease Management program. The American College of Obstetrics and Gynecology clinical practice guidelines for pregnancy and related complications were also adopted and incorporated as the basis for the High Risk OB Disease Management program. For every project, where evidence-based clinical practice guidelines and best practice protocols are available, they are reviewed by the QMC and PAC, adopted, and incorporated as the basis for member and provider education and other interventions. Other evidence-based clinical practice guidelines, such as the American Diabetic Association guideline for diagnosis and treatment of diabetes and the guidelines for assessing and managing obesity, have also been adopted and are the basis for projects related to these topics.

HealthCare USA continues to effectively manage the credentialing and recredentialing needs of the provider network. New providers continue to be added to the network and existing providers are re-credentialed at least every 36 months. The credentialing department function was moved to the provider relations department in November of 2008. The 15 delegated credentialing entities have continued to pass annual on-site oversight evaluations and routine reporting requirements. Monthly calls with the Credentialing Verification Organization (CVO) were established to improve ongoing coordination and collaboration between the CVO and Provider Relations staff working in this area.

In 2008, MO HealthNet expanded its service to 14 additional counties. In response to the planned expansion, Network Development added twelve hospitals in the expansion counties and seven large provider groups to our network to meet the needs of new membership.

This year, the quality improvement team increased the number of provider on-site medical record reviews and the content reviewed with each on-site visit. Medical records and claims are now reviewed at least every 36 months in accordance with the recredentialing cycle and/or when a quality of care issue or safety issue is identified that is cannot be resolved with a documentation request. The chart audit tool has been enhanced to not only assess for EPSDT, HEDIS elements, and general documentation guidelines, but to also review for evidence of adherence to evidence based clinical practice guidelines for asthma and diabetes. Claims are also reviewed for consistency between documentation in the clinical record and claims data submitted to HealthCare USA. On-going provider education is completed with each visit.

While very few providers scored less than 80% during 2007 and 2008, a plan of correction and schedule to re-audit continue to be completed for those who do score less than 80%. The most frequent issue identified with the addition of claims review is a lack of claim/encounter filing for services provided.

Improving coordination of care and services with subcontractors and other providers through improved communication and collaboration has been a significant focus in 2007 and 2008. Mental health services are contracted to MHNet, dental services to Doral Dental, transportation services to MTM and pharmacy adjudication to Caremark Pharmaceuticals. In addition to routine attendance and reporting to the QMC, co-locating behavioral and medical care management and combined rounds as described earlier, MTM and Doral Dental participate in rounds on an ad hoc basis. Both actively participate and report activities at QMC meetings and participate in other on-going performance improvement activities.

Provider complaints, grievances and appeals and member grievances and appeals have been an area of focused improvement starting in 2007, and on-going through 2008. A multi-disciplinary, interdepartmental team focuses efforts on decreasing the rate of complaints, grievances and appeals received. The team also monitors overturn rates and timeliness on an on-going basis. This PIP team meets routinely to review data accuracy, identify trends, complete barrier analyses related to interventions tested and define new interventions or tests of change.

A Registered Nurse, who is also a Certified Professional Coder, was added to the Complaints, Grievances and Appeals staff. Her sole responsibility is to assist in resolving complaints in house in order to improve timeliness.

Lists of members who have conditions that are particularly sensitive to transportation issues are now sent to MTM routinely and an education session on the impact transportation can have on outcomes for members with high risk pregnancies, asthma, diabetes and sickle cell disease was completed at MTM for all phone staff. A decrease in transportation related complaints was subsequently achieved and has been maintained.

Doral Dental increased participation in community events, including for example, the High Risk OB Peer to Peer Educational Baby Shower, to increase opportunities for live interaction and discussions with members about their needs and desires. Outcomes of interventions are reviewed with subcontractors at monthly calls, and representatives from subcontractors actively participate on performance improvement teams on an ad hoc basis.

The utilization management staff and medical directors monitor performance data including number of calls received, turn around times, denial rates, overturn rates, and the outcomes of inter-rater reliability and documentation chart audits. New resources have been dedicated to increasing current and new employee knowledge through participation in InterQual train-the-trainer education programs and implementation of a revised process and tool for on-going member file reviews and interactive case presentations and discussions. A performance improvement project focused on improving evidence of consistency in application of InterQual criteria and documentation to reduce variability in denial and overturn rates is in development, with an anticipated start date by the end of first quarter of 2009.

Strengths and Accomplishments
In 2007 and 2008, HealthCare USA continued to collaborate and share best practices with national resources and subject matter experts, and partnered with local community based stakeholders to more efficiently and effectively implement programs to continue to improve clinical, functional, cost, satisfaction and safety related outcomes of care and service.

In addition to programs focused on member and provider services and assuring on-going contract compliance, HealthCare USA sought and achieved full URAC accreditation in 2007. "URAC is a not-for-profit organization that promotes continuous improvement and efficiency of health care management through process of accreditation, education and measurement." (URAC, 2007) The accreditation process evaluates quality procedures, operations and accountability for health care organizations through nationally recognized, publicly available standards, thus increasing transparency for consumers, providers and regulators.

As a result of our commitments and efforts, in addition to URAC accreditation, the following list are examples of some of the successes HealthCare USA achieved during 2008, in improving member access to quality healthcare, improving outcomes of care and services and reducing costs:

- Expansion of the Balanced Scorecard for on-going tracking, trending and comparison to goals for key clinical, operational, safety and satisfaction measures resulting in earlier identification of opportunities for improvement and successes achieved.
- Enhancement of employee knowledge including:
  - the State contract, fraud and abuse, HIPAA and national URAC standards throughout the Plan.
  - Completion of InterQual train-the-trainer program
  - Completion of Patient-centered interviewing skills workshops
  - Establishment of an organization wide team to complete implementation of the CLAS standards for cultural competency by end of 2nd quarter, 2009, including multiple opportunities for provider participation in training.

- Improved collaboration, coordination, and information sharing with providers, subcontractors and members through:
  - Expansion of PCP on-site visits and establishment of routine PMAC meetings for education in areas such as: documentation, communicable disease reporting, mental health access, medical record management, access standards, 24-hour availability requirements, HEDIS and EPSDT, evidence based clinical practice guidelines, and HealthCare USA requirements.
  - Improved coordination of care across practice settings with establishment of routine daily patient rounds, case management and grand rounds, co-locating mental health and inclusion of high volume practice sites.
  - Successful completion of a pilot Peer to Peer educational baby shower incorporating mentoring of high risk OB members by members who delivered, but had high risk pregnancies.
- Improvement in EPSDT participation ratios, HEDIS Measures and CAHPS scores through:
  - On-going provider education and successful implementation of a provider payment for completion of a claim code modifier for the post partum visit.
  - Successful deployment of member incentive programs for pregnant member's adherence to prenatal and post partum visits and for asthmatics adherence to NAEPP asthma guidelines for PCP visits, medication refills and identification of a rescue person.
  - Implementation of a report for statistical comparison including significance testing for HEDIS rates from year to year and individual provider report cards.
- Continued expansion of interdepartmental and cross care settings, multi-disciplinary performance improvement teams to address over and under utilization and patient safety including (but not limited to):
  - Non-urgent/avoidable emergency ED project
  - Hospital readmissions
  - Synagis Utilization
  - Post-partum depression
  - Grievances and Appeals
- Continued evaluation and improvements in the special needs processes.
- Continued to develop new and enhance existing strategic community partnerships in all regions to improve equitability as evidenced by:
  - Successful community health fairs providing physicals, dental screenings and other services in the local communities of all three regions.
  - Successful implementation of rural dental fairs.
  - Successful pilot of a student nurse internship program and medical record abstractors and coders externship program.
- Improved processes to assess member and provider satisfaction and to identify needs and gain subject matter expertise by:
  - Revised the member program specific satisfaction surveys.
  - Expanded active participation on the High Risk OB Task Force and Asthma Task Force to include external subject matter expertise.

HealthCare USA believes the following have been key to our success:

- Support of an organizational framework for quality improvement that encourages on-going active learning, knowledge sharing, team work and open communication.
- Development and enhancement of technologies to identify actionable opportunities and track, trend and report clinical and non-clinical service, safety and satisfaction metrics.
- Commitment to collaborate and align incentives with members, stakeholders and other organizations for performance improvement activities focused on improving outcomes of care, service and safety to maximize timeliness, efficiency, effectiveness, patient-centeredness and equitability.
- Commitment to continuously improving organizational and administrative capacity to assure that enrollee's protection remain the focus of our work.

Opportunities for Improvement
Continue efforts to increase our network of appropriate providers, particularly specialists, to continue to improve equitability and timeliness, and reduce out-migration, as evidenced by both access and availability metrics for all services covered under the current contract and any future expansions.

- Continue efforts to improve monitoring mechanisms that support the ongoing evaluation of our network and ensure that all services covered are available and accessible to members while avoiding unnecessary out-migration of services.
- Continue to improve clinical and non-clinical outcomes for safety, efficiency, effectiveness, timeliness and patient-centeredness by increasing the number of members screened, enrolled and actively participating in appropriate well care activities, case management or disease management services and programs.
- Continue to identify opportunities to improve member adherence to treatment and preventive/well-care guidelines, by testing different interventions to eliminate real and perceived barriers to care and services, with success evidenced by improved EPSDT participation ratios and HEDIS rates and decreases in over and under- utilization of services..
- Continue to collaborate with the State regarding screening data on members with special health care needs, lead screening and other processes that impact care and services for all MO HealthNet managed care members across the state.
- Continue to evaluate and refine member outreach educational activities and mechanisms to improve safety, efficiency and effectiveness, and patient-centeredness of outreach activities.
- Continue to monitor and improve information management through on-going internal and external data reporting, record reviews, and review of provider and member feedback processes.
- Continue to improve the processes and tools utilized to assess and measure key aspects of quality of care, quality of services, and safety.
- Continue to educate and implement the CLAS standards for cultural competency and to partner with community organizations to decrease disparities in healthcare across Missouri.
- Continue to improve working relationships and coordination internally and with providers and members by seeking input and feedback to align incentives, improve quality of care,

quality of service, as measured by CAHPS and program specific satisfaction surveys, and safety.

- Continue to seek input and feedback from and collaborate with members to reduce barriers to care and services and continue to improve member satisfaction.
- Identify gaps in care and continue to address collaboration with the mental health vendor for continuity in care for members with behavioral health needs and co-morbid medical and behavioral health conditions.
- Continue to assess and improve, in conjunction with the dental vendor, pediatric member access to routine dental care.
- Continue to assess and identify gaps in consistency and equity in utilization denials and approvals with on-going education and inter-rater audit tools.
- Institute a regular, on-going, interdepartmental and interdisciplinary forum for patient safety concerns and projects.

Missouri Care

Quality and Compliance Committees
Several committees oversee the Missouri Care Quality Improvement Program. The structure of the committees is presented in Figure 1. All quality committees report up through the Quality Management Oversight Committee (QMOC), which has ultimate accountability for the quality management program.

The following is a description of each of the quality committees, their roles and key issues identified through these committees in SFY 08.

Figure 1: Missouri Care Quality Committee Structure
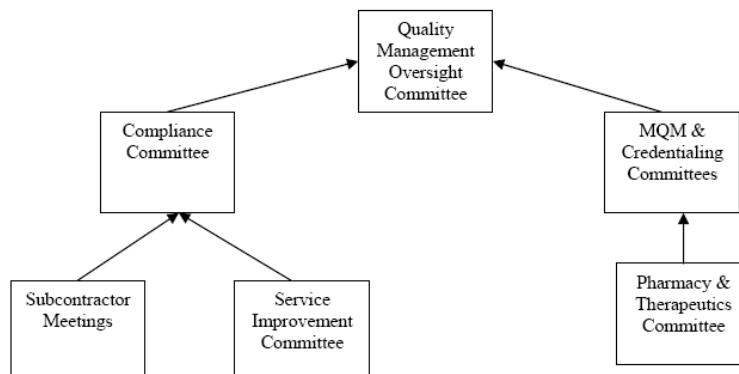
Medical Quality Management Committee (MQM)
The MQM Committee advises and makes recommendations to the Senior Medical Director (SMD) and to the QMOC on matters pertaining to the quality of care and services provided to members. The committee is made up of a diverse body of providers from the Missouri Care network. The Committee uses the peer review process to evaluate and address specified care, service, or utilization issues arising from the activities of health care professionals or providers in order to improve the quality and appropriate utilization of health care available to members.

During this reporting period, the MQM Committee met every other month. The committee reviewed eleven potential quality of care cases that were elevated to the committee by the SMD. After reviewing the cases the committee determined that there were no quality of care concerns in three of the cases, seven were assigned a Severity Level I and one case was assigned a Severity Level III. Severity Levels assigned by the committee designate the quality of care or utilization issue's seriousness and options for further action after review of the issues. All levels of severity are tracked and any further action documented in the health care professional or provider's file.

The committee also advised Missouri Care on Performance Improvement Projects, approved the annual Quality Management and Utilization Plans and Work Plans, and provided input on HEDIS performance measure improvement initiatives.

Credentialing Committee
The Credentialing Committee advises the Senior Medical Director on the credentialing and recredentialing of health care providers in the Missouri Care provider network. The committee is made up of a diverse body of providers from the Missouri Care network. The committee met six times in SFY 08.

During this period, 344 providers were presented to the committee for initial credentialing and 158 were presented for recredentialing. The committee recommended final approval of 339 of the initial credentials and 158 of the recredentials. The committee chose to deny 5 provider initial credentials. The committee also reviewed the annual audit reports of the 7 delegated credentialing organizations. Corrective action was taken for one delegate and another delegate was given until July 2008 to finish credentialing all of its providers. That delegate did complete the credentialing requirements.

Pharmacy and Therapeutics (P&T) Committee
The Senior Medical Director is responsible for directing and overseeing management of Missouri Care's pharmacy services with the advice and participation of the Pharmacy and Therapeutics Committee (P&T).

Missouri Care contracts with Express Scripts, Inc. (ESI) for pharmacy benefits management. ESI administers the pharmacy benefit through a network of pharmacy providers. However, Missouri Care is responsible for oversight of pharmacy activities, utilization and quality concerns, resource management, and complaints.

The P&T and ESI Committees met four times in SFY 08, and provided the following: formulary review, clinical pharmacy reviews (requests for prior authorization and non-formulary medications) and tracking high volume, high cost drugs. The P&T committee implemented one pharmacy benefit change: quantity limits for narcotics and benzodiazepines. The committee researched the feasibility of a 14-15 day supply of medications but decided not to implement due to compliance concerns. Lastly, the committee continued a Polypharmacy Project to address misuse and/or abuse of narcotics, and to decrease the likelihood of harmful medication interactions. Members fitting the target profile are enrolled in case management. ESI provides ongoing education to retail pharmacies.

Missouri Care's pharmacy generic fill rate increased from 75 percent to 78 percent during this reporting period. ESI continued to work on decreasing the price of single-source brand prescriptions and fulfilling its' contractual obligations to Missouri Care's as the pharmacy benefits manager.

Service Improvement Committee (SIC)
The SIC advises and makes recommendations to the QMOC and Missouri Care Management about member and provider service concerns. During SFY 08, 84 issues were brought to committee and all

were reviewed and resolved. The major concerns for this time period were pharmacy and dental issues. Formulary questions are forwarded to Missouri Care's Senior Medical Director for peer-to-peer education, while cases suggestive of substance abuse are referred to case management. Missouri Care was well aware of the dental issues facing our members, specifically regarding accessibility, and as a result, chose to contract with a new dental provider effective on September 1, 2008.

Quality Management Oversight Committee (QMOC)
The committees previously described and the Compliance Committee report to the QMOC. The QMOC integrates quality management activities throughout the health plan and provider network. The committee is made up of the Missouri Care management team. The team met six times, or every other month, during SFY 08. The committee reviewed the minutes and issues from the other quality committees. Additionally, each department manager reported on his or her own internally developed measures of quality. Examples include NICU admission rates, percent of claims received through EDI, and member and provider appeals. The content and completeness of the measures were reviewed during the SFY08 and revised as appropriate.

Compliance Committee
The Missouri Care Compliance Committee is a part of the existing Missouri Care QMOC. The Compliance Committee is comprised of the same permanent members of the QMOC. During compliance meetings, issues are discussed that include, but are not limited to, HIPAA issues, policies and procedures, state notifications, state reporting requirements, and fraud and abuse.

The Compliance Committee tracked 57 issues in 2007. Most of the reported issues were resolved within the same month. All issues can be identified by one of the following four categories:

Reportable Compliance Items
Reportable compliance items include search warrants, interviews/investigations, risk management issues, reports to the compliance hotline or exit interviews. There was one reportable compliance items reported in 2007. This issue has been resolved.

Suspected Fraud and/or Abuse
Suspected fraud and/or abuse items include issues related to providers, members, employees or subcontractors. There were 22 suspected fraud and/or abuse items reported in 2007. Cases included various pharmacy lock-ins for members referred to Missouri Care from the State for aberrant drug utilization patterns and/or behavior and state referrals of providers who had lost their licensure.

Security Incident
A security incident can include issues related to human life and safety, systems and data, or facilities. There were 29 security incidents reported in 2007. All were system issues that have been resolved.

Privacy
A privacy issue can include review of proposed disclosure, request for records, accidental disclosures or complaints. There were 29 privacy items reported in 2007. They included accidental disclosures of PHI, balance billing members, incorrect "Pay To", one subpoena for member information, member requests for records, proposed disclosures of member PHI and claims issues.

Compliance issues can be reported verbally or in writing to the compliance officer or any member of management. Members, providers, employees or others may report issues anonymously on Missouri Care's compliance hotline.

Analysis of Quality Improvement Process

Missouri Care's process of quality improvement is one of constant evaluation. Missouri Care annually reviews its Quality Management Plan to identify any needed changes to the plan. Changes may include improvements in quality initiatives or follow-though in any instances in which Missouri Care did not adhere to the plan. Missouri Care also develops a quality management work plan each year. (See Appendix B for the 2009 QM work plan.) The plan is used to set priorities and to guide continuing or new quality initiatives. It is referenced and updated as needed throughout the year. The plan is also used at the end of the year to identify quality processes that were successful and processes that need to be changed or replaced in the next year. The Quality Department is responsible for the overall quality plan, but Missouri Care strives to have a quality program that is integrated across departments. Missouri Care also relies on its provider network to evaluate and make recommendations to its' quality improvement process.

Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments
Below are the highlights of Missouri Care successes in delivering quality services to members and network providers in SFY 08:

• Increased EPSDT participation rate to 76.92% in calendar year 2007. The rate for calendar year 2006 was 70.78%

• Increased performance from HEDIS 2007 to HEDIS 2008 (measurement years 2006 to 2007) on the following measures: Adolescent Well Care; Cervical Cancer Screening; Childhood Immunizations Combo 3; Chlamydia Screening for age group 21-25; Follow-up after Hospitalization for Mental Illness - 30 day; and Use of Appropriate Medications for People with Asthma.

• Exceeded NCQA's 75th percentile benchmark for MO HealthNet Managed Care Plans on the following
  HEDIS measures: Cervical Cancer Screening (76.35%); Timeliness of Prenatal Care (91.1%); Postpartum Care (70.83%); and Well Child Visits in the First 15 Months of Life (68.63%).

• Missouri Care's performance on the Cervical Cancer Screening measure remained best-in-state, and at 76.35%, it is just one percentage point lower than the 2008 NCQA HEDIS 90th percentile of 77.42%. Two other measures placed Missouri Care in the 90th percentile of all MO HealthNet health plans: Timeliness of Prenatal Care (91.1%) and Postpartum Care (70.8%).

• Implemented four clinical Performance Improvement Projects (PIP) to improve member access/compliance with medical recommendations: 1) Increase compliance of members diagnosed with persistent asthma using a controller medication, 2) Adolescent well care visits, 3) WIC partnership to increase well-child visit rates, and 4) Chlamydia screening. One non-clinical PIP focused on improving follow-up appointments within 7 and 30 days of discharge from an inpatient stay for mental illness. Several improvements in care were documented.

• Medical management successfully supported a significant increase in utilization with the expansion of managed care in February 2008 to 10 additional counties and for 10,000 additional members. Although outpatient visits increased to 454 per 1000 member months, the ER visit rate has remained statistically unchanged over the past three years (78.3 visits per 1000 member months). The medical management team remained compliant with the prior authorization regulatory turn around time of two business days, and continued to perform within case management monthly regulatory requirements.

- Maintained NCQA accreditation of Missouri Care's disease management program.

- Increased rating of Customer Service in the annual Consumer Assessment of Health Plans (CAHPS) Survey to 79.3% in 2007 from 70.9% in 2006.

- Maintained phone abandonment rate compliance across Prior Authorization, Behavioral Health and Member Solutions Departments, at 2.27 %, 2.38 %, and 1.89 % respectively. This is well below the goal of less than 5%.

- Maintained average speed of answer for phone calls at 11 seconds, 14 seconds, and 12 seconds respectively for Prior Authorization, Behavioral Health, and Member Solutions, respectively. This is below the goal of 30 seconds.

- Provider relations maintained a very stable provider network while also developing a robust new network in the 10 expansion counties. By the end of June 2008, the network had grown to 608 PCPs, 1,893 specialists, and 533 behavioral health providers. Missouri Care scored 97% on the 2008 Network Access Plan submitted to the Missouri Department of Insurance.

- The Fraud and Abuse team met state standards in monitoring provider and member complaints, as well as delegation activities. In SFY 08 Missouri Care received no state sanctions.

- Successfully migrated claims payment, prior authorization, membership and provider network data management systems from QMACs to QNXT.

- Posted 76% EDI claims submission in 2007, up from 71% in 2006.

Challenges and Opportunities for Improvement
The following are areas for improvement:
- Improve dental access/annual HEDIS dental screening rates
- Improve well child visits for members three, four, five, and six years of age
- Continue to improve lead testing rates
- Decrease emergency department utilization
- Increase cultural competency initiatives

Molina Healthcare of Missouri

MHMO's organizational structure for supporting Quality Improvement begins with the Board of Managers. The MHMO Board has the ultimate authority and responsibility for the quality of care and service delivered by MHMO. The Board is responsible for the direction and oversight of the QIP and delegate's authority to the Quality Improvement Committee (QIC) under the leadership of the Chief Medical Officer and the Plan President.

Quality and Compliance Committee
MHMO's QIC is responsible for the overall continuous quality improvement (CQI) program. The QIC is chaired by the Chief Medical Officer and co-chaired by the Plan President. It is

composed of the Directors and Managers of key health plan functions. The purpose of the QIC is the following:

- Strategic quality planning to determine the goals and objectives for quality improvement to meet the needs of customers
- Provide proactive leadership for systemic quality improvement in care and service
- Evaluate the provision of resources to meet goals and objectives
- Monitor performance in meeting the goals and objectives
- Integrate and coordinate quality improvement activities
- The QIC confirms and reports to the Board of Managers that plan activities comply with all state, federal, regulatory and NCQA standards.
- The QIC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up.
- The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments within MHMO's network. Analysis of Utilization Management and QI data play a key role in determining such actions.

Quality Improvement Sub-Committees
The QIC delegates QI functions to specific Quality Improvement sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHMO Quality Sub-committees meet quarterly or more frequently and keep contemporaneous minutes using a standard format.

The following Sub-committees report to the QIC:

1. *Utilization Management Committee (UMC)*
   Members: Chief Medical Officer - Co-chair, Director of Quality Improvement - Co-chair, Associate Medical Director, Chief Operations Officer, Chief Financial Officer, Director of Utilization Management, Director of Information Systems, Director of Contracting, Director of Member Services, Director of Provider Services, Contracted Practitioners

   Roles/Functions:
   - Review and approve the Utilization Management Program, Medical Coverage Guidelines, Work Plan and the criteria used to review authorization decisions.
   - Review, assess, and recommend internal utilization management practices used for selected diagnoses or disease classes.
   - Review and analyze data reported on outcomes and trend studies. Recommend additional studies and/or changes in data collection to improve the reports available for review.
   - Conduct under/over utilization monitoring by selected diagnoses, product line and practice type as well as assisting utilization management staff to set appropriate over/under utilization trend reports.
   - Evaluate member and provider satisfaction with the utilization program annually

- Make recommendations that assist the staff to improve relationships with members and community providers
- Review denial/appeal trends and identify opportunities for improvements
- Monitor Inter-Rater Reliability studies for each review group; i.e., medical directors, nurses, authorization reviewers, etc.
- Monitor compliance with external regulatory and accreditation body requirements
- Review utilization information from delegated groups

2. *Professional Review Committee (PRC)*
   Members: Chief Medical Officer - Co-chair, Director of Quality Improvement - Co-chair, Associate Medical Director, Director of Utilization Management, Director of Compliance, Director of Contracting, Director of Provider Services, Contracted Practitioners

   Roles/Functions:
   - Reviews the credentials of practitioners/providers and renders decisions regarding initial participation and continued participation in the MHMO network based on MHMO's Credentialing Program policy.
   - Evaluates selected quality of care concerns forwarded from Member Service, Provider Services, the QI Department or the Peer Review Panel as they relate to individual practitioners/providers. It renders decisions concerning continued participation
   - Evaluates member satisfaction concerns and/or complaints forwarded from Member Service, Provider Services or the QI Department as they relate to individual practitioners/providers
   - Evaluates results of Medical Record Audits, including individual Practitioner corrective action plans
   - Approves the MHMO Credentialing Program policies and procedures
   - Monitors on-going performance of delegated group credentialing activities

3. *Clinical Quality Improvement Committee (CQIC)*
   Members: Chief Medical Officer - Co-chair, Quality Improvement Analyst - Co-chair, Director of Quality Improvement, Director of Utilization Management, Director of Compliance, Director of Pharmacy Services, Director of Member Services, Manager of Utilization Review, Manager of Healthcare Analysis, Special Needs Case Manager

   Roles/Functions:
   - Review monthly member demographics as it represents the overall MHMO's member population
   - Provide regular clinical measurement oversight, recommend new opportunities or changes in current programs and interventions to improve clinical care and service
   - Review Molina's Clinical Practice and Preventive Guidelines for use annually, at a minimum

- Identify and monitor key quality indicators that measure performance against clinic practice guidelines, external benchmarks and internal targets
- Provide oversight of all Disease Management and Health Education programs
- Assist with development and oversight of all clinical aspects of the QIP and the QI Work plan
- Assist with development, review and maintenance of clinical QI policies and procedures
- Review and analyze adverse events and pharmacy lock-ins
- Development and assessment of Performance Improvement Projects

4. *Compliance Committee (CC)*
   Members: Chief Medical Officer - Co-chair, Director of Compliance – Co-chair, Director of Quality Improvement, Director of Utilization Management

   Roles/Functions:
   - Establish and maintain a process to monitor, audit, conduct inquiries and investigations regarding compliance matters
   - Distribute the Code of Conduct, as well as written policies and procedures that promote and pertain to compliance
   - Promote the development and implementation of regular, effective education and training programs addressing compliance issues and responsibilities
   - Create and maintain of processes that permit persons to make anonymous and/or confidential, good faith reports of instances of suspected non-compliance
   - Develop a system to consider, investigate and respond to good faith reports of instances of suspected non-compliance
   - Develop protocols for consistent enforcement of appropriate disciplinary action, including termination, against persons who have engaged in acts or omissions constituting non-compliance
   - Enlist the use of audits, investigations and other evaluation techniques to identify areas of compliance deficiency, to monitor ongoing compliance and to assess the effectiveness of compliance corrective measures
   - Monitor all policies and procedures for compliance with State and federal laws governing
   - Adherence to the confidentiality and privacy of health information

5. *Member/Provider Satisfaction Committee (MPSC)*
   Members: Chief Medical Officer - Co-chair, Quality Improvement Analyst- Co-chair, Director of Quality Improvement, Director of Utilization Management, Director of Compliance, Director of Member Services, Director of Provider Services

   Roles/Functions:

- Monitor service Quality Improvement efforts and activities, including but not limited to: Availability of Practitioners, Accessibility of Services & Member Satisfaction
- Monitor internal and external customer service by analysis of member and provider satisfaction surveys in an effort to achieve exceptional customer service
- Explore new methods to improve member and provider satisfaction and identify improvement activities going forward
- Review company policies and procedures related to service Quality Improvement activities (standards listed above) and propose changes or amendments as appropriate
- Identify patterns of complaints through member and provider complaints, grievances and appeals. Development of non-clinical Performance Improvement.

6. *Pharmacy and Therapeutics Committee (P&TC)*
   Members: Chief Medical Officer - Co-chair, Director of Pharmacy Services - Co-chair, Director of Quality Improvement, Associate Medical Director, Director of Utilization Management, Director of Compliance, Manager of Case Management, Contracted Practitioners, Chief Operating Officer, Chief Financial Officer, Director of Contracting, Director of Member Services, Director of Provider Services, PBM Clinical manager, PBM Account Manager

   Roles/Functions:
   - Approve Pharmacy policies and procedures
   - Oversee Pharmacy QI activities
   - Manage Formulary development and maintenance
   - Recommend additions and deletions to the formulary
   - Oversee communication about Pharmacy and Formulary changes to practitioners
   - Evaluate drug utilization patterns and develop interventions when appropriate
   - Develop and implement programs to enhance member and provider satisfaction

7. *Delegated Oversight Committee (DOC)*
   Members: Chief Medical Officer - Co-chair, Director of Compliance - Co-chair, Director of Quality Improvement, Director of Utilization Management, Director of Pharmacy Services

   Roles/Functions:
   - Ensure fulfillment of clinical and contractual obligations by all delegated contractors, including corrective action follow-up.
   - Maintain accountability and oversight of delegated administrative functions, including but not limited to: credentialing, utilization management, and claims to contracted vendors/provider groups.

- Oversee care coordination of groups delegated Medical Management functions.
- Monitor ongoing delegated compliance via reports and annual on-site assessments.
- Designate department manager(s) to work with the DOC and coordinate and conduct annual on-site assessments, produce reports, and oversee corrective action processes.
- Develop effective delegation oversight documents such as P&P, pre-assessment and monitoring tools, and delegation agreements.
- Report and make recommendations to the QIC regarding delegation oversight

Analysis of Quality Improvement Process

Quality Improvement is a data driven process. Analysis of data is vital in assessment of the overall effectiveness of the Quality Improvement programs. MHMO's activities have been identified through a program evaluation, ongoing measurement and analysis to evaluate its strengths and accomplishments. Sources of data analyzed include, but are not limited to the following:

- Encounter data
- Claims data
- Pharmacy benefit management data
- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaints through call tracking, UM, Provider Services and other sources
- Provider and member satisfaction survey results
- Complaint, Grievance and Appeal data
- Statistical, epidemiological and demographic member information
- Authorization and denial data
- Enrollment; regional, disenrollment trends
- HEDIS and EQRO survey results
- Behavioral Health data
- Geo-Access provider availability data and analysis

Overall Effectiveness of the Quality Improvement Program
Program Strengths and Accomplishments

MHMO's QIP has proven its effectiveness through the achievement of HEDIS scores that were within the range of the previous year's results, the results of the Performance Improvement Projects and the measurement of performance indicators. The QIC continues to play a positive role in guiding the focus of the QIP to effectively measure the quality of care and services provided to MHMO's members. Strengths and accomplishments include:

- Completion of clinical and non-clinical Performance Improvement Projects
- Continued improvement of HEDIS scores

- Facilitate organization efforts to achieve State and local regulatory compliance and NCQA accreditation in 2011
- Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members. These programs include preventive health, health education, and disease management guidelines.
- Utilization of multi-disciplinary and multi-dimensional teams to address process improvements that can enhance care and service, including primary, specialty and behavioral health practitioners as appropriate.

Opportunities for Improvement
- Continue to monitor performance measures
- Continue efforts to increase HEDIS scores in areas of cervical cancer screening, childhood immunizations and adolescent well care visits.
- Continued effort to increase CAHPS scores through Member Services and Provider Relations.
- Ongoing development and evaluation of current clinical Performance Improvement Project through analysis of adverse events, member population, and risk factors.
- Identify opportunities to strengthen member safety activities.
- Evaluate resources, training, scope, and content of the program and practitioner participation.
- Identify limitations and barriers and make recommendations for the upcoming year, including the identification of activities that will carry over into next year.

This page intentionally left blank.

Population Characteristics

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Race/Ethnicity
BA+ is sensitive to the ethnic composition of its members. The following table illustrates the membership ethnicity. BA+ does not vary in cultural and ethnic membership compared to the general population demographics of the Kansas City Metro Area.

Race	Count	% of Total
White (Non-Hispanic)	16,851	59.0%
Black (Non-Hispanic)	10,230	35.8%
Asian or Pacific Islander	49	0.2%
Hispanic	411	1.4%
Other/Unidentified	1,025	3.6%
TOTAL	28,566	100%

Special Needs
The BA+ Special Programs Coordinator coordinates the flow for referrals made by the MO HealthNet Division for members with Special Health Care Needs, Lead Case Management and Consent Decree. BCBSKC has policies and procedures that outline the processes followed. The process has been enhanced by incorporating reporting and assessment protocols that identifies more information about the special needs member. There are several attempts to reach the members on the list to screen them for potential case management needs. If they meet BCBSKC/BA+ case management criteria, they are further evaluated for case management. Screening tools are included in the policy and procedure. This process is followed by the BCBSKC/BA+ Case Management department. Referrals are made as needed to New Directions Behavioral Health, the High Risk Prenatal program and the Asthma Disease State Management program.

Utilizing the Special Health Care Needs data to identify members with Special Health Care Needs is a requirement of MHD. BCBSKC reviews claim data to identify other members that might require case management services for Special Health Care Needs. BCBSKC continually reviews the screening tool and makes revisions to questions as deemed necessary.

Special Needs Statistics

Members in Lead Case Management	FY2008
Lead Level 0-14	17
Lead Level over 15	6
Consent Decree	NA*
Modified Consent Decree	NA*
Special Health Care Needs Children	
Number on list	585
Number referred for case management assessment	36

Family Support Division offices were converting to a new reporting system during this measurement period.

Languages Identified

During the BA+ enrollment process, each member's primary language is identified. BA+ provides interpretation services to assist members in communicating with BA+. The use of the AT&T language line provides an alternative for communication when language differences exist. Ongoing monitoring of the language line usage provides a mechanism for evaluating significant differences in BA+ member's needs.

Measurement is conducted on a quarterly basis to determine what languages are spoken by members. The following is an analysis of the information provided through the State Eligibility File transmission. Even though we have not exceeded the contract requirement of 200 members or five percent of membership who speak a single language other than English as a primary language (contract requirement 2.8.2), BA+ does provide some materials in Spanish.

Language Spoken	3Q07	4Q07	1Q08	2Q08
Blank	10,713	11,016	11,720	12,424
American	7	4	8	10
Arab	-			
Chinese	2	1	1	1
English	14,977	14,700	14,568	15,048
No Response	-			
Other	950	710	117	105
Polish	1	1	1	1
Russian	1	1	1	1
Spanish	103	95	93	99
Vietnamese	173	17	14	16
LAOT	0	0	0	1
Total	26,927	26,545	26,523	27,706

Opt-Outs

According to the termination information provided by the State of Missouri MO HealthNet Division, fifteen members opted out of BA+ for SSI in FY2008.

Children's Mercy Family Health Partners

Race/Ethnicity
Race and ethnicity are not data elements that we receive in our data from the State; therefore we are unable to report on race and ethnicity.

Special Needs
CMFHP has a dedicated full-time Outreach Coordinator to identify and screen our Special Health Care Needs population.

In 2007, through monthly excel spread sheets from the State, Children's Mercy Family Health Partners Special Health Care Needs Outreach Coordinator identified the following number of individuals within our membership that had special health care needs:

Year	Identified SHCN members	Number of SHCN members already in CM when identified	Number of SHCN members screened	Number in Consent Decree
2007-2008	1252	22	957	267

The Special Health Care Needs Coordinator identifies members who are not already in Case Management, attempts to screen the member through outreach phone calls or letters.
If Case Management services are indicated, the member is referred to a CMFHP Pediatric or Lead Care Manager, Asthma Health Coach or Health Lifestyles Health Coach.

Languages Identified
Children's Mercy Family Health Partners membership consists of individuals who have a variety of primary languages. The following is a breakdown of our membership in 2007 and 2008 and the primary languages spoken:

Language	2006 Members	2007 Members
American Sign	28	26
Arabic	18	17
Bosnian		1
Chinese	6	8
Cambodian	1	1
English	41,778	46,732
Haitian	2	0
Korean	0	2
Polish	0	0
Romanian	0	2
Russian	2	1
Spanish	1,593	1,194
Tagalog	24	42
Vietnamese	61	48
Other	184	95
TOTAL	43,697	48,169

Summary by language of translation services:
Based on the numbers above, CMFHP has a large Hispanic population. CMFHP has five full time Hispanic Customer Service representatives who are available from 7am to 6pm (Monday through Friday) to assist the Hispanic community. CMFHP also employs two full time Hispanic Community Outreach Representatives who answer questions and provide outreach activities to those who are prospective members. These representatives can also provide back-up to Customer Service in answering questions for members if needed.

CMFHP also has access to a language line that can be used to assist non-English speaking members with translation services. In 2007, CMFHP changed to Propio Language Services, a local corporation, for member and provider translation services. Along with this agreement, we secured translators for languages that were not available with a previous vendor.

In Fiscal Year 2007 and 2008, CMFHP did not identify anyone who needed communication accommodations outside of the services described above.

Summary of services to members with visual or hearing impairments or disabilities:
Children's Mercy Family Health Partners members have access to a toll free TDD line. When requested, copies of printed materials are available and provided via cassette, CD or in large print versions.

Inventory by language of member materials translated:
The following materials are provided in English and Spanish:
- Quarterly member newsletter (Connection)
- Member brochures
- Non-Emergency Transportation brochure
- Member Handbook
- CMFHP information handout
- First Touch OB Case Management brochure
- Urgent care brochure

Inventory of member materials available in alternative formats:
CMFHP utilizes access to a toll free TDD line. When requested, copies of printed materials are provided via cassette or in large print versions.

Opt-Outs
In 2006, CMFHP had 17 members opt out of managed care. In 2007, we had 37 members opt out of managed care. The following describes the types of ―Opt Outs" for these 2 years:

	2006	2007
DSS Opt-Out	0	1
Alternative Care Opt-Out	13	12
SSI Opt Out	4	24
Total	**17**	**37**

Harmony Health Plan of Missouri

Race/Ethnicity
Population Mix Overview
Harmony Health Plan (HHP)(A member of the WellCare Group of Companies) serves 10,920
MO HealthNet
eligible recipients within the Eastern Region of Missouri. Harmony has 56 associates to serve the
participating MO HealthNet population and is conveniently located in the Metro East community
of
Belleville, Illinois; an additional 3,668 associates support Harmony Health Plan from Harmony's
regional headquarters in Chicago, Illinois and the WellCare corporate campus located in Tampa,
Florida.

Population:
Harmony's Missouri membership population totaled 10,920 as of June 30, 2008. The majority of
the enrollees (80% of the total membership), are 20 years of age and younger. Females comprise
58% of the population and in comparison to the male population, have a higher number of
enrollees in every age group except the 0 - 6 year olds. The most significant variance is noted in
the 21 - 42 year olds with males representing 15% of that age group. Of the 2210 enrollees 21
years of age and older, 85 % or 1868 are female.

Age: (June 2008)
Largest health care population is age 0-18 (74%).
Next largest population is age 21-42 (18%).

Sex: (June 2008)
58% of the 10,920 of our members are female.

Harmony Health Plan MO HealthNet Medicaid Membership (June 30, 2008)

Age	Male Enrollees	Female Enrollees	Total Number of Enrollees
0-6	2106	1927	4033
7-17	1881	2126	4007
18-20	259	411	670
21-42	280	1647	1927
43-64	62	221	283
65 and older	0	0	0
totals	4588	6332	10920

Opportunities 2008/2009
Harmony Health Plan has the ability to report the number of members by sex, age and area
however due to reporting constraints and validity of State file data relative to ethnicity HHPI
does not have the ability to report by ethnicity at this time.

Race / Ethnicity

As Harmony Health plan of Missouri (HHP) does not report specific ethnic breakdowns of the total membership, it is prudent to apply the general MO HealthNet breakdown to HHP. Considering this, it is important to note that the majority of HHP members can be expected to be of the minority population and will have special health care needs.

The literature documenting racial and ethnic disparities in access to health care in the United States is growing. African Americans and Latinos, for example, are less likely to have a consistent source of care and are more apt to consider the emergency department their medical care home than whites are, even after controlling for socio-demographic differences (Walls, Rhodes, and Kennedy 2002; Weinick, Zuvekas, and Cohen 2000; Zuvekas and Weinick 1999). Minorities also are less likely to use any medical services or to receive preventive care, and their rates of preventable hospitalizations and unmet health needs are substantially higher than those of whites (Gaskin and Hoffman 2000; Hargraves and Hadley 2003; Schneider, Zaslavsky, and Epstein 2002). Furthermore, minority Americans are disproportionately affected by physicians' limited participation in MO HealthNet, since African Americans, Latinos, and Native Americans are two and half times more likely to have MO HealthNet coverage than whites are (Hoffman and Wang 2003).

Special Needs

Data from September 2008 report for MO Special Needs Population received by Case Management:

>   No Answer: 10%
>   No Phone Number: 43%
>   No Record: 43%
>   Opened to Case Management: 4%

The Special Needs Report is received by Case Management and the Case Coordinator attempts to reach the member. The Case Coordinator conducts the mini-screening upon contact with the member, and upon eligibility and member's consent to participate in the program. The Registered Nurse contacts the member and conducts a comprehensive assessment previously scheduled by the Case Coordinator.

The Registered Nurse creates a Care Plan and reviews it with the member/ family. The PCP or treating specialist receives a copy of the Care Plan.

The member remains in Case Management until 80% (or higher) of goals have been reached.

See Process below:

Special Healthcare Needs Process
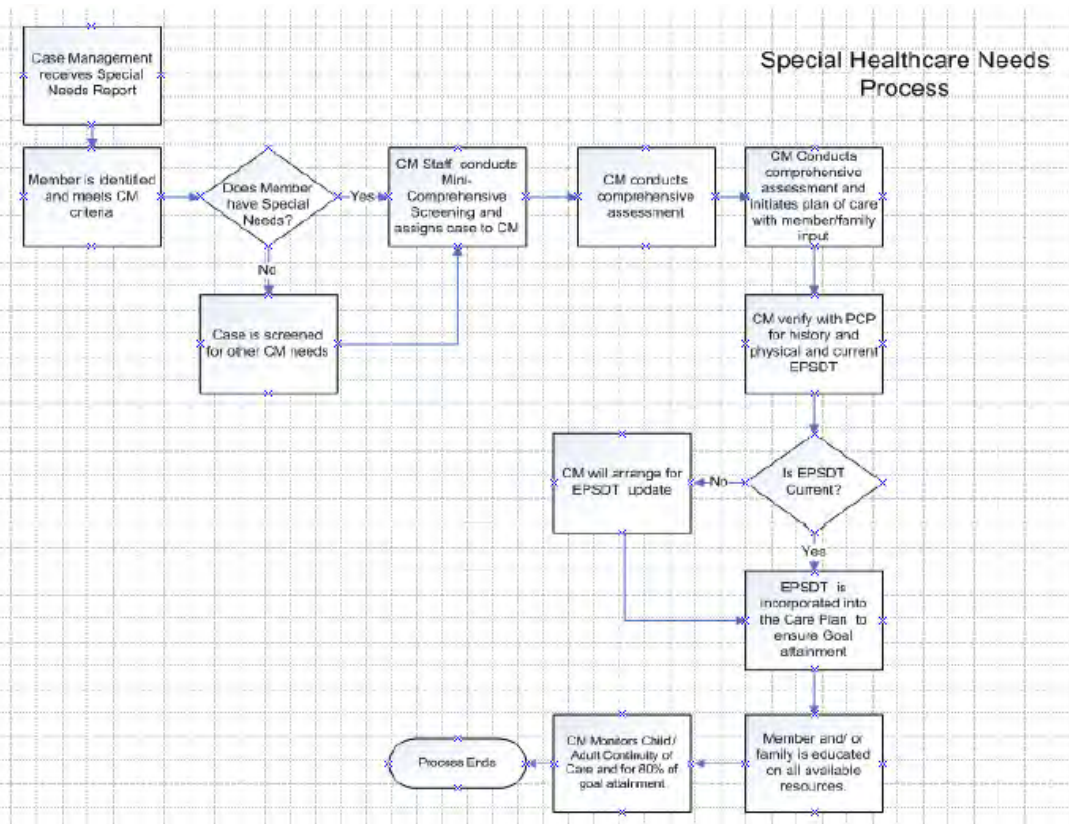
Opportunity for Improvement:
Opportunities for improvement have been identified by Case Management and a change in process has been implemented. Case Managers began sending letters to member who have been identified as unable to reach or ―no phone number‖ and ―no answer‖.

Case Management continues to focus on increasing the number of members who have access to the services the program offers to Special Needs Children in Missouri.

Success Story:
A 9 month old infant was referred to Case Management to assist with coordination of services. Infant's diagnosis was Erbs Palsy causing extreme weakness, sometimes paralysis of the arm caused by injury (usually during birth) to the brachial plexus (network of nerves near the neck that give rise to all the nerves of the arm). These nerves provide movement and feeling to the arm, hand, and fingers.

Non-Surgical intervention was not successful or did not improve function.

Brachial Plexus Surgery was recommended. Infant had the Brachial Plexus Surgery in June 2008.

Rehab Services were recommended to improve strengthening of the arm.

The Case Manager worked with the family and the provider to coordinate services with the Rehab Facility and that family to ensure the member would attend scheduled visits. The Case Manager also made sure that family was given instruction on a home rehab program (exercises—passive range of motion) and that family was adhering to the recommendations.

Discussion by Case Manager and family/facility report infant is making great progress. He has increasing strength in upper arm and finger flexion.

Case remains open in Case Management for continued support and coordination of care.

Languages Identified
In the 2006-2007 contract year, Harmony identified three languages (Arabic, Spanish and Vietnamese) other than English that were primarily spoken by our members. However the percentage of members primarily speaking non-English languages was less than 1 percent of the Harmony's total membership. The grid below shows the languages and percentage of members who primarily use a language other than English. There was very little change in primary languages spoken in the 2007-2008 contract year.

Languages	2006-2007	2007-2008
Arabic	0.16%	0.23%
English	99.06%	99.03%
Spanish	0.62%	0.67%
Vietnamese	0.16%	0.07%

Opt-Outs
Harmony Health Plan received 13 approved opt outs from DSS from July 1, 2007 through June 30, 2008. The opts outs covered 18 members. The dominant reason for opting out of the Plan was to return to the fee-for-service plan. We believe an opportunity may exist to further reach out to members and providers to educate them on the benefits of the MO HealthNet managed care program and, more specifically Harmony.

We have further identified the 2nd most common reason for opting out of Harmony appears to be the perception that other MO HealthNet plans have better benefits. We have asked our Product Management department to review benefits across all states WellCare participates in, as well as those of our competitors in Missouri, to determine if we can further enhance our value added benefits for our MO HealthNet members.

Below is the breakdown by reason for the opt outs.

# of Members	Month/Year	Reason for Opt Out
3	O7/07	Dr. suggested and hospital only takes straight Medicaid (1); Returned to Fee-For-Service
5	10/07	Better benefits (1); Dr. takes straight Medicaid (4)
1	11/07	Better benefits – SSI
1	01/08	Returned to Fee-For-Service
1	02/08	Returned to Fee-For-Service
3	03/08	Returned to Fee-For-Service
1	04/08	Returned to Fee-For-Service
3	06/08	Better Benefits (1); Dr. takes straight Medicaid (2)

HealthCare USA

HealthCare USA saw an increase in membership in the first quarter of 2007 from the acquisition of the FirstGuard membership. At the end of FY 2008, there was an overall slight increase in membership. The county expansion increased membership in the Central region, reflected in the upward trend from 12/31/2007 through 6/30/08. Eastern and Western regions had a very slight decline in FY 2008.

HealthCare USA Membership

	12/31/06	6/30/07	12/31/07	6/30/08
Eastern	119,545	118,721	116,192	114,700
Central	20,824	20,171	19,191	27,770
Western	10,379	38,607	34,797	35,731
Total	150,748	175,699	170,180	178,201

Source: Enrollment
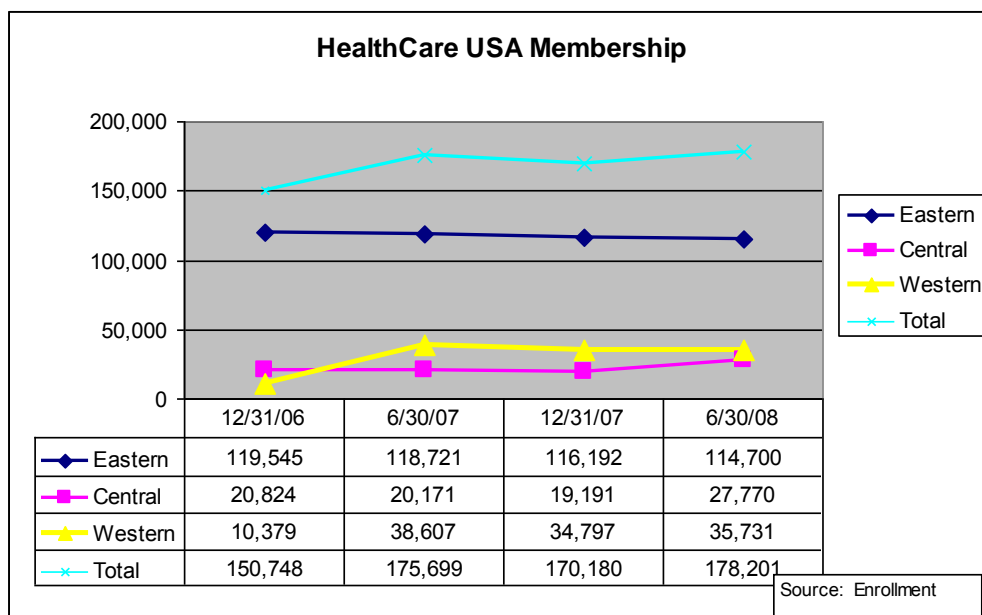
Race/Ethnicity
HealthCare USA has established strong partnerships with agencies and organizations dedicated to improving the lives of minority cultures and disparate populations in Missouri. Some of the agencies are: Black Health Care Coalition, Hispanic Chambers of Commerce, Mexican Consulate, Urban League of Metropolitan St. Louis, 27th Ward Infant Mortality Reduction Initiative, Maternal Child and Family, Teen Pregnancy Prevention Partnership, Minority Health Alliance Eastern Region, and Caring Communities.

Some of the largest ethnic events that HealthCare USA has either sponsored or participated in include:
- Vietnamese Council Resource Fair
- Greater St. Louis Hispanic Festival
- International Institute's Festival of Nations
- Fiesta in Florissant
- Binational Health Fair
- Fiesta Hispanica
- Fiesta in the Heartland
- Guadalupe Center Health Fair Cinco de Mayo
- Multicultural Forum in Cole County

Not only do we recognize and support ethnic communities within our regions, but we also acknowledge the differences between urban and rural communities. We have strengthened our partnerships in many rural areas by regularly attending monthly community action agency meetings and participating in local events such as:
- Phelps County Back-to-School fair
- Macon County Back-to-School Fair
- Pulaski County Back-to-School Fair
- Laclede County Back-to-School Fair
- Maries County Back-to-School Family Fair in Benton County
- Morgan County Annual Health & Diabetes Awareness Fair
- Girls on the Run 5K Walk-Run
- Lafayette County Dental Fairs

Special Needs
Members with special needs continue to be identified primarily by MO HealthNet at the time of enrollment. The majority of members identified are less than 21 years old. Others are identified and referred through sources such as readmissions data, outcomes of the internal NRC health risk assessment, concurrent review, PCP referrals and even member self-referrals.

Number of Members Identified with Special Needs at Time of Enrollment

Increase due to increased membership through county expansion

- Central
- Eastern
- Western

Data source: MO Healthnet
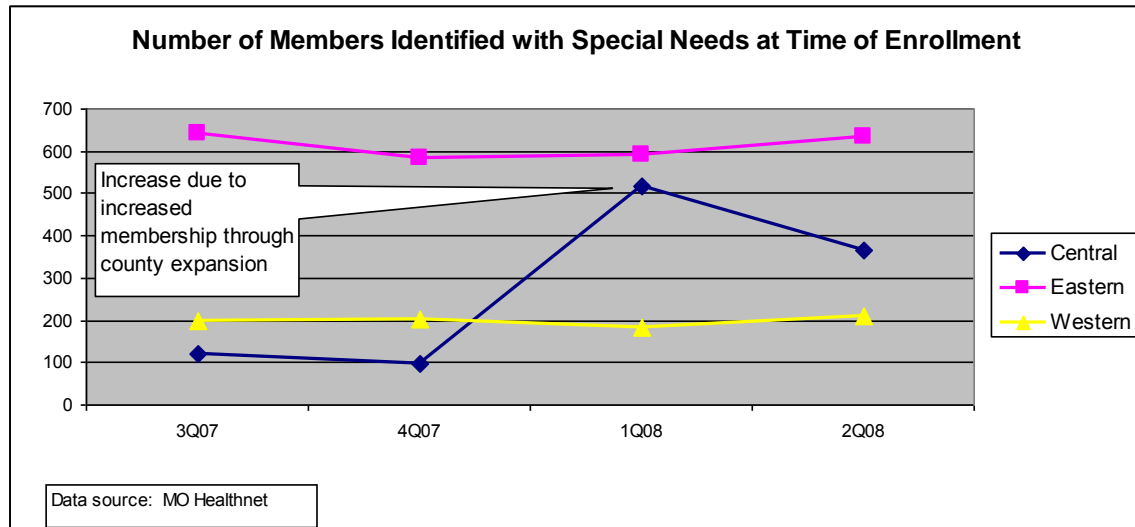
Counts remained fairly constant except for an increase in the Central region due to county expansion.

Languages Identified

HealthCare USA membership is comprised of individuals, who upon enrollment, may declare languages other than English and those with visual or hearing impairment. The principal languages as defined by the State contract are English and Spanish. Other languages with a significant membership include Vietnamese, Arabic, Chinese Mandarin and Russian (see chart below).

Members' Declaration of Primary Language Spoken August 2, 2008:

Language	Count	Rate
English	110,031	60.46%
Undetermined	71,404	39.23%
Spanish	361	0. 20%
Vietnamese	77	0.04%
Arabic	53	0.03%
Russian	38	0.02%
Chinese	24	0.01%
Sign	2	0.00%

This diverse membership requires both translation of written materials and oral interpreter services. HealthCare USA employs Spanish speaking staff in the customer service department. HealthCare USA provides telephonic translation services through Network Omni and face-to-face translation services throughout all three regions by contracting with the following agencies: Language Access Metro Project (LAMP), Jewish Vocational Services, International Institute, A-Z Translating Services, and AAA Translation. Interpreter services for hearing impaired members are provided through Deaf Inter-Link, Deaf Expression, Inc. and DEAF Way. In the first six months of 2008, there were 1300 requests for face to face translation services, a 25%

increase over third and fourth quarters 2007. A breakdown of face-to-face language translation requests is shown below.

	Q1, Q2 2008	Q3,Q4 2007
ALBANIAN	0	2
AMHARIC	0	0
ARABIC	69	28
BOSNIAN/CROATIAN/SER	80	80
BURMESE	27	00
CHINESE-CANTONESE	5	0
CHINESE-MANDARIN	3	2
DARI (AFGHANI)	53	72
ETHIOPIAN OROMO	0	0
FRENCH	0	0
HINDI	2	0
KOREAN	0	0
KUNAMA	1	0
PERSIAN (FARSI)	0	0
RUSSIAN	47	43
SIGN	18	20
SOMALI	72	65
SPANISH	850	572
SWAHILI	6	14
TURKISH	1	0
URDU	1	8
VIETNAMESE	65	62
Total	**1300**	**974**

HealthCare USA contracts with Network Omni for member telephonic translation. Total requests for translation services in first two quarters of 2008 were 1462. This is a 12 percent increase over previous two quarters. The following languages were requested in order of frequency: Spanish, Chinese Mandarin, Chinese Cantonese, Russian, Portuguese, Italian, Arabic, Polish, Bosnian, Vietnamese, Albanian and French.

HealthCare USA's 24-hour nurse hotline employs bilingual staff supplemented as needed by a third party translation service. They also support members needing TDD/TTY services via a local TTY access number.

HealthCare USA offers the member handbook translated into Spanish, Bosnian, and Vietnamese to meet the needs of our non-English speaking members. —Nodle Soups", one-page educational handouts targeting specific health-related topics, are distributed to members through events and meetings. Our current topics translated in Spanish include:
- La importancia de Lavar tus manos (Importance of Hand Washing)
- Sea sabia(o), vacune a sus hijos! (Be Wise, Immunize)
- Controlando el peso de su nino (Controlling Your Child's Weight)
- Despues de las vacunas (After vaccinations)

Other HealthCare USA translated materials are Necesita su hijo SEGURO DE SALUD (Does Your Child Need Health Insurance?), Habran Interpretes Disponibles (Interpretation Services), and Las primeras semanas de su bebe (Baby's First Weeks). A lead poison prevention coloring book has been translated into Bosnian.

HealthCare USA's website offers a fun, educational health and wellness-related program, *Kid's Health*, to anyone with access to a computer. *Kid's Health* offers a variety of physician approved articles such as: Managing Home Health Care for Children in Wheelchairs, Camping for Special Needs Children, Bullying, Everyday Illness and Injuries, and Dealing with Feelings. Parents, teens and children may access hundreds timely, age appropriate articles, interactive games and healthy recipes. In addition, there are over 1100 articles translated into Spanish.

To meet the needs of our speech, hearing and visually impaired members the member handbook is also offered in Braille and audio upon request. There have been no requests in the past four quarters for any of these alternative versions.

There have been no grievances related to language services submitted over the past year.

Opt-Outs

For FY 2008, there were 99 members who opted out of HealthCare USA, with the majority (61 out of 99 or 62 percent) of the opting out occurring during the first and second quarters of 2008 with and just after the county expansion occurred. When drilling down on the reasons for opting out, the most frequent reason provided was ―better benefits.‖ An increase in opting out based on ―better benefits‖ was seen, again, after the county expansion. The same pattern during the first and second quarter is evident with the second most common reason provided for opting out, ―provider issues.‖ There was a related increase in March 2008, after the county expansion. The remaining months show no trends or patterns. The rate of opting out and the reasons will continue to be collected and tracked to identify trends and potential actions to address trends.

57

Reasons for Opting Out

Reason	Number of Members
Unknown	7
Medical	16
Mental Helath	5
Better Benefits	42
Adopted	7
Provider	22

Data Source: State of MO

Reason for Opting Out: Better Benefits

County expansion

Month	Number of Members
7/07	3
8/07	2
9/07	3
10/07	2
11/07	3
12/07	2
1/08	5
2/08	2
3/08	8
4/08	2
5/08	3
6/08	5

Data Source: State of MO

Reason for Opting Out: Provider Issues

County Expansion

Month	Number of Members
7/07	1
8/07	0
9/07	3
10/07	0
11/07	0
12/07	1
1/08	2
2/08	1
3/08	7
4/08	1
5/08	5
6/08	2

Data Source: State of MO

Missouri Care

Race/Ethnicity
The State provides Missouri Care with race and ethnicity data on enrolled members. Missouri Care does not fully utilize this information because it is not captured in QNXT, our data management system. This will be a primary area of focus in 2009, as Missouri Care enhances its' cultural competency initiatives. Currently, the health plan's case managers address cultural needs on a one-to-one basis.

Special Needs
Missouri Care recognizes the challenges that families with children who have special health care needs (CSHCN) face when navigating the health care system. These children often have complex medical, social and behavioral health care needs. Missouri Care is contracted with the University of Missouri Hospitals and Clinics, which has specialists capable of providing a medical home to the CSHCN population. Missouri Care works in conjunction with these providers to improve access to care. A second strategy of the health plan was to bring the management of behavioral health in house, and the medical behavioral care integration process has continued to improve clinical outcomes. Thirdly, Missouri Care recognized the need for care/case managers to assist CSHCN families in navigating a health care system made more complex due to their multiple needs. Although our provider network supports coordination of care through a medical home, providers often lack the time and resources to identify and follow-up with these children. Missouri Care's case management nurses have available to them a centralized data system with both predictive modeling and case tracking capabilities, so that they can identify and support more families than is possible by individual providers.

Missouri Care uses the following sources of data to identify and treat children with special health care needs:
- MO HealthNet Division monthly file
- Predictive modeling[1]
- Pharmacy utilization
- Inpatient utilization
- Durable Medical Equipment requests
- ER utilization

Missouri Care utilizes the Children with Special Health Care Needs (CSHCN) Screener to identify children experiencing one or more current functional limitations or service use needs as a result of ongoing physical, emotional, behavioral, and developmental conditions. In addition, Missouri Care continues to contract with the Missouri Partnership for Enhanced Delivery of Services (MO-PEDS) to improve the quality of care for rural and underserved children with special health care needs. MO-PEDS utilizes the medical home model of care by increasing the availability of care coordination in 18 counties in central Missouri. In this reporting period, 1,887 members were identified with special needs as reported by MO HealthNet. Following completion of the CSCHN screener, 546 were enrolled in case management.

---

[1] The predictive modeling database is a proprietary database used to identify members likely to be future high utilizers of care, based on claims and diagnostic data. The system is used to assess a member's risk level and subsequently identify appropriate case management interventions to effectively improve the member's outcome.

Languages Identified

Missouri Care tracks the number of members who speak a language other than English. During SFY 08, approximately 3 % of members were identified as speaking a language other than English. The majority of these members, 57.5 %, identified Spanish as their primary language. Interpreter services are available for all members regardless of their native language, and written materials are available to members in Spanish. Members are informed of these options in the member handbook. Missouri Care also attempts to call all new members. If during a new member call, a member or household identifies Spanish as his/her primary language, a Spanish-translated member handbook is mailed to the member.

Opt Outs

During SFY 08, twelve opt outs were reported to the health plan by the MO HealthNet division. The reasons for disenrollment were: doctor takes straight MO HealthNet, better benefits, and no reason or nonclassified reason given.

Molina Healthcare of Missouri

Race/Ethnicity

All members will be treated equally, fairly and provide covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or mental disability, except where medically indicated.

Special Needs

MHMO continues to increase identification and outreach to children with special health care needs. Special Needs members are identified in a variety of ways. The MO HealthNet Division ("MHD") sends an electronic file of children with special health care needs monthly to MHMO. The Special Needs Coordinator evaluates the data, and for each member (or parent or guardian) contact is attempted. Members (or parents/guardians) are educated on available benefits and the necessary resources are provided in an effort to prevent complications or unnecessary delays in seeking care.

Another method of identifying children with special needs is via the MHMO Clinical Case Management staff. Hospitalized children who develop special needs through illness, injury or premature birth are identified by Clinical Case Managers and referred to the Special Needs Coordinator. The intent of this program is to identify members with special needs, coordinate care and initiate case management services. When multiple needs are identified and coordination of care is required, the Special Needs Coordinator will refer the member to the appropriate Complex Case Manager. The Complex Case Managers are responsible for the evaluation and management of complicated medical cases, high-risk social situations and those members with unique medical needs.

Languages Identified

Access to care is a key component of creating positive health outcomes. MHMO has implemented the following to eliminate barriers to care:
- Member Services bi-lingual translators on site – Bosnian and Spanish
- Community Outreach and Education services

- Translators through LAMP (office) and Language Line (telephone)
- Spanish prompt added to phone tree
- Translated marketing and educational materials

MHMO examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MHMO tracks data on the volume of members who have been identified as speaking a language other than English MHMO's current membership reports reflect a total of 499 eligible members that speak Spanish. Incorporated into MHMO's practitioner orientation program is education on processes to access interpreters for members.

Foreign Primary Language 11/19/2008			
Primary Language	Members	% of Total Members	All Members
SPANISH	499	0.65%	77043
OTHER	267	0.35%	77043
BOSNIAN	183	0.24%	77043
VIETNAMESE	87	0.11%	77043
ARABIC	55	0.07%	77043
CHINESE	32	0.04%	77043
RUSSIAN	29	0.04%	77043
ASL	2	0.00%	77043
ROMANIAN	2	0.00%	77043
HAITIAN	1	0.00%	77043
LAOTIAN	1	0.00%	77043
TAGALOG	1	0.00%	77043
TURKISH	1	0.00%	77043
Totals:	1160	1.51%	77043

Opt Outs
The data below reflects the members who were approved for opt out of MHMO as reported to MHMO by MHD. MHMO will continue to track and manage the member opt out information.

Opt Outs	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
	9	16	35	17	77

This page intentionally left blank.

Quality Indicators

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Performance Measures

Effectiveness of Care

1	(H) Childhood Immunization Status (CIS)		Combo 2 66%	Combo 3 54%
2	(H) Adolescent Immunization Status (AIS)		Combo 2 NR	
3	(H) Cervical Cancer Screening (CCS)		65%	
4	(H) Chlamydia Screening in Women (CHL)		50%	
5	(H) Follow-up after Hospitalization For Mental Health Disorders (FUH)	7-day follow-up	51%	
		30-day follow up	75%	
6	(H) Use of Appropriate Medications for People with Asthma (ASM)	Ages 5-9	94%	
		Ages 10-17	86%	
		Ages 18-56	80%	
		Combined	87%	

Access/Availability of Care

7	(H) Prenatal and Postpartum Care (PPC)	Timeliness of Prenatal Care	NR
		Postpartum Care	NR
8	(H) Annual Dental Visit (ADV)	2-3 y/o	11%
		4-6 y/o	33%
		7-10 y/o	42%
		11-14 y/o	38%
		15-18 y/o	31%
		19-21 y/o	17%
		Combined	33%

Satisfaction with the Experience of Care

	(H) CAHPS 3.OH Child/Adult		2008	2007	2006	2005	2004	2003
9		Getting Needed Care	82%	80%	81%	84%	81%	79%
		Getting Care Quickly	79%	78%	80%	79%	79%	79%
		How well Doctors Communicate	90%	89%	92%	90%	90%	89%
		Courteous and Helpful Office Staff	91%	90%	92%	91%	90%	91%
		Customer Service	74%	64%	77%	77%	72%	75%
		Rating of Personal Doctor	83%	80%	78%	78%	79%	77%
		Rating of Specialist	81%	79%	77%	86%	80%	71%
		Rating of Health Care	84%	82%	80%	76%	82%	80%

Use of Services

10	(H) Well child Visits in the First 15 Months of Life (W15)	0 visits	3%
		1 visits	4%
		2 visits	6%
		3 visits	9%
		4 visits	15%
		5 visits	23%
		6 or more visits	40%
11	(H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)		NR
12	(H) Adolescent Well-Care Visits (AWC)		35%

13	(H) Ambulatory Care (AMB)	Ambulatory Care (Total)		Outpatient Visits		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
		Age	Member Months	Visits	Visits/ 1000 Member Months	Visits	Visits/ 1000 Member Months	Procedures	Procedures / 1000 Member Months	Stays	Stays/ 1000 member Months
		<1	25,217	20999	832.73	2564	101.68	131	5.19	55	2.18
		1--9	138,392	41786	301.94	6945	50.18	564	4.08	77	0.56
		10--19	99,652	20077	201.47	4821	48.38	338	3.39	172	1.73
		20--44	50,819	14110	277.65	6503	127.96	568	11.18	453	8.91
		45--64	3,080	1224	397.40	342	111.04	71	23.05	14	4.55
		65--74	13	11	846.15	5	384.62	0	0.00	0	0.00
		75--84	2	2	1,000.00	0	0.00	0	0.00	0	0.00
		85+	0	0	NA	0	NA	0	NA	0	NA
		Unknown	0	7		0		0		0	
		Total	317,175	98,216	309.66	21,180	66.78	1,672	5.27	771	2.43

14	(H) Mental Health Utilization - Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services (MPT)	NR					
15	(H) Identification of Alcohol and Other Drug Services (IAD)	Inpatient Chemical Dependency Services		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent
		158	0.60%	17	0.06%	233	0.88%

Trends in MO HealthNet Quality Indicators

1	Trimester Prenatal Care Began:	Jan-Sept 2007		Significant
		Births	*Percent*	*Change****
	First	4,195	75.6%	Yes
	Second	1,115	20.1%	Yes
	Third	167	3.0%	No
	None	71	1.3%	Yes
	Total	5,548		
2	Inadequate Prenatal Care	1096	20.40%	Yes
3	Birth weight (grams) - total number of births by weight category for each live birth.	*Births*	*Percent*	*Change****
	<500 Grams	16	0.3%	No
	500-1499 Grams	87	1.5%	No
	1500-1999 Grams	90	1.5%	No
	2000-2499 Grams	321	5.4%	No
	2500 Grams	5,380	91.3%	No
	Total	5,894		
4	Low Birth Weight (<2500 grams)	*Births*	*Percent*	*Change****
		514	8.7%	No
5	Method of Delivery	*Births*	*Percent*	*Change****
	C-Section	1,433	24.3%	No
	VBAC	61	10.6%	No
	Repeat C-Section	512	89.4%	No
	Total	5,898		
6	Smoking During Pregnancy	*Births*	*Percent*	*Change****
		1,386	23.5%	Yes

7	Spacing <18 months since last birth	Births	Percent	Change***
		557	16.7%	No
8	Births to mothers <18 years of age	Births	Percent	Change***
		338	5.8%	No
9	Repeat teen births	Births	Percent	Change***
		204	3.5%	No
10	Fetal Deaths (20+ weeks) Rate per 1000 Live Births	Births	Rate	Change***
		21	3.6	No
11	Total live birth or stillbirth fetuses 500 grams or more Rate per 1000 population	Births	Rate	Change***
		5,864	197.6	No
12	Percent of pregnant women on Women's Infants and Children Program (WIC)	Births	Percent	Change***
		4,584	78.1%	No
13	VLBW not delivered in level 111 hospitals	Births	Percent	Change***
		17	17.7%	No
14	Average maternal length of stay (days), Inpatient admissions	Total	Days	
		5,920	2.7	

15	Average newborn length of stay (days), Inpatient admissions	Average Length of Stay	
	Total Newborns	3.64	
	Total Well Newborns	2.23	
	Total Complex Newborns	16.04	
16	Average behavioral health length of stay (days), Inpatient admissions	Total	Days
		7,790	7.9
17	Asthma admissions under age 18, Inpatient admissions Rate per 1000 Population	Number	Rate
		218	1.1
18	Asthma admissions 4-17 Inpatient admissions Per 1000 Population	Number	Rate
		149	1.0
19	Asthma admissions ages 18 - 64, Inpatient admissions	Number	Rate
		836	1.2
20	Emergency room visits under age 18 Per 1000 Population	Number	Rate
		51,598	266.3
21	Emergency room visits ages 18 - 64 Per 1000 Population	Number	Rate
		241,010	344.8
22	Hysterectomies Per 1000 Population	Number	Rate
		1,769	5.1
23	Vaginal hysterectomies	Number	Percent
		590	33.4%
24	Preventable hospitalization under age 18 Per 1000 Population	Number	Rate
		1,089	5.6

HEDIS® Indicators by Missouri Medicaid Managed Care Plans within Regions: Live Births
Blue-Advantage Plus of Kansas City, Inc.

Indicator Name	2006 Rate*	2005 Rate*	2004 Rate*	Significantly different from MEDICAID Managed Care	State Rate	2006 Number	Total Deliveries
Cesarean Sections	23.0	23.3	22.8	Low	Low	443	1,925
Vaginal Birth After Cesarean (vbac)	15.2	4.8	13.8	High	High	25	165
Adequacy Of Prenatal Care	84.9	86.8	85.9	No	Low	1,474	1,737
Early Prenatal Care	76.7	81.7	84.4	No	Low	266	347
Low Birth Weight (lbw, Less Than 2500 G)	12.4	7.2	9.6	No	High	40	322
Low Birth Weight (lbw, Less Than 2500 G) Delivered In Level Ii/Iii Hospitals	89.9	84.0	89.0	No	High	178	198
Very Low Birth Weight (vlbw, Less Than 1500 G) Delivered In Level Ii/Iii Hospitals	90.6	76.7	68.4	No	No	29	32
Smoking During Pregnancy	30.2	28.4	29.4	High	High	581	1,925
Spacing Less Than Eighteen Months	15.8	15.9	14.6	No	High	169	1,069
Births To Mothers Less Than 18 Years	5.8	5.1	6.1	No	High	111	1,925
Repeat Births To Teen Mothers (Less Than 20 Years)	3.4	3.8	3.4	No	High	66	1,925
Prenatal WIC Participants	77.7	74.8	79.0	High	High	1,491	1,919

*Per/1000

Children's Mercy Family Health Partners

Performance Measures

Children's Mercy Family Health Partners must meet program standards for monitoring and reporting of HEDIS Quality Indicators as outlined in the MO HealthNet managed care contract. An annual report of the MCOs HEDIS Quality Indicators is due in accordance with the state contract. All data is reported to the Administrative and Medical Oversight Committees and the Board of Directors (Governing Body). Data points are plotted over time and compared with State and national benchmarks. Opportunities for improvement are discussed and evaluated.

Improvement initiatives implemented based on Children's Mercy Family Health Partners' HEDIS Indicator results included:

- Yearly wellness reminders and schedules were mailed to members for children, adolescents, women and men (Spring 2008 Member Newsletter)
- Cervical cancer screening and chlamydia screening letters were sent to identified members and their providers to promote increased screening rates.
- Performance improvement projects were initiated for annual dental visits and adolescent well care visits.
- Coordination and collaboration with behavioral health subcontractor to assess decreased rates and improve rates in the Mental Health Follow up in 7 and 30 days post-hospitalization measures, and
- Continued the required statistical analysis of rates from year to year to the HEDIS audit contract.

In the following slides, several abbreviations are used.

CMFHP   Children's Mercy Family Health Partners
HP   Healthy People 2010
RFP   MO Health Net Contract-Request for Proposal

All vertical axis numbers are percentage of the population receiving services

Childhood Immunizations
Combo 3

Cervical Cancer Screening*

Chlamydia Screening (16-26)*

FHP Results (6% increase)
HEDIS Medicaid Mean
MOHealthNet State Averages

62.24
59.54
59.6
58.08
59.23
55.27
58
53.36
50.06
50.09

60
55
50
45
40
35

2000 2001 2002 2003 2004 2005 2006 2007

*Audited Measure
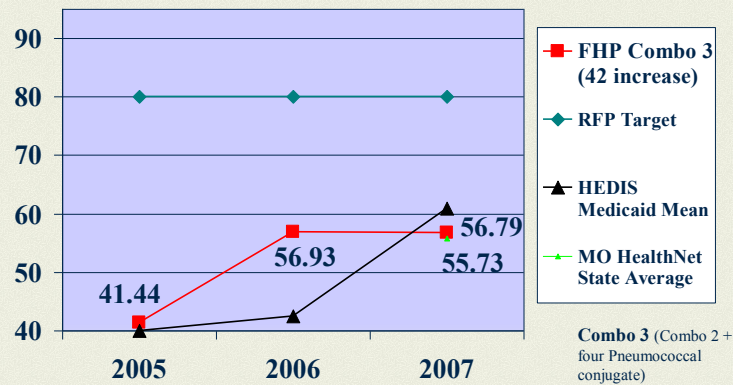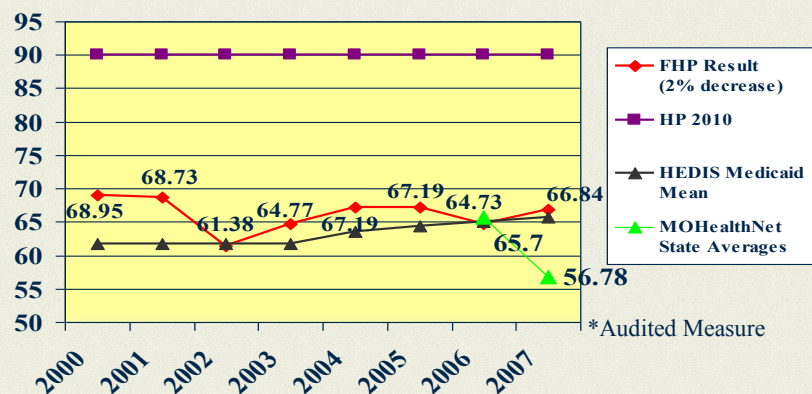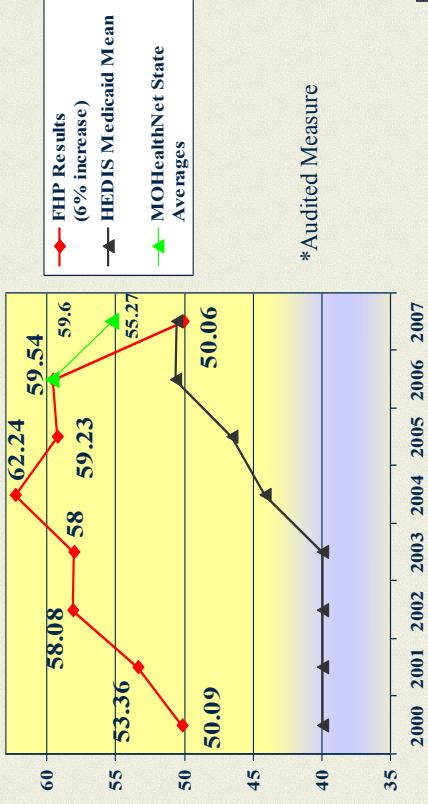
10

Use of Appropriate Medication For People with Asthma (Combined Rate 5-59)*

FHP Result (44% increase)
HEDIS Medicaid Mean
MOHealthNet State Averages

90.57 89.73
89.34
90.57 85.9 87
85.43
72.77
66.57
58.94

90
85
80
75
70
65
60
55

2001 2002 2003 2004 2005 2006 2007

*Audited Measure
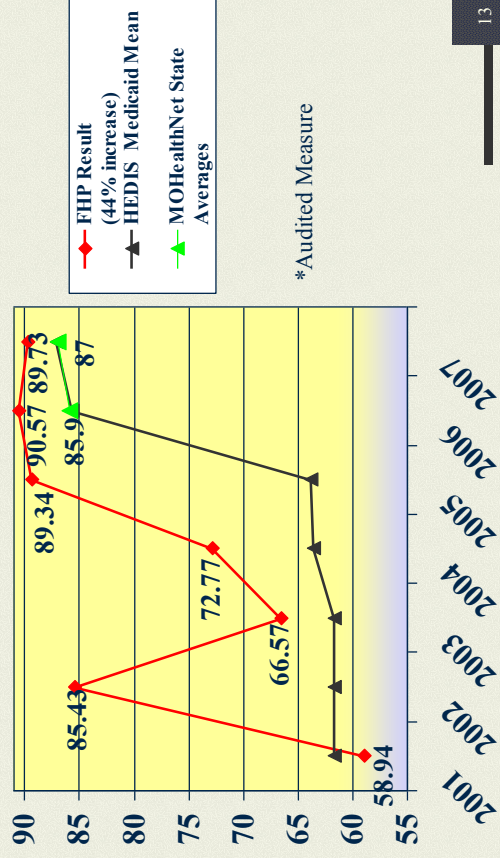
13

Mental Health F/U after Hosp (7days)
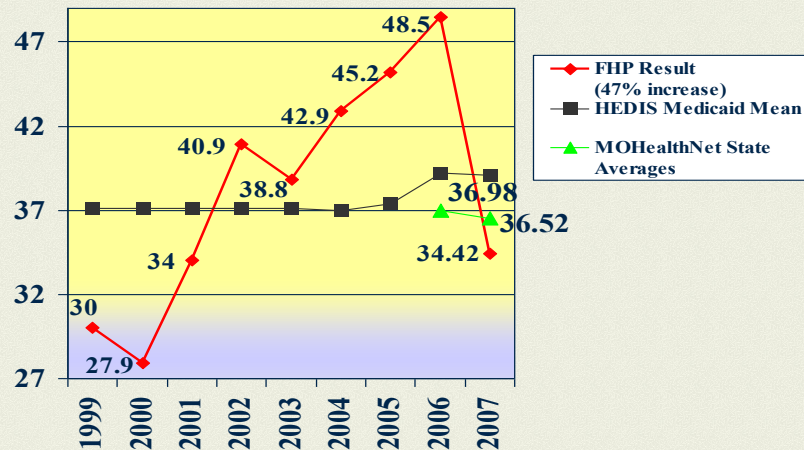
Mental Health F/U after Hosp (30 days)
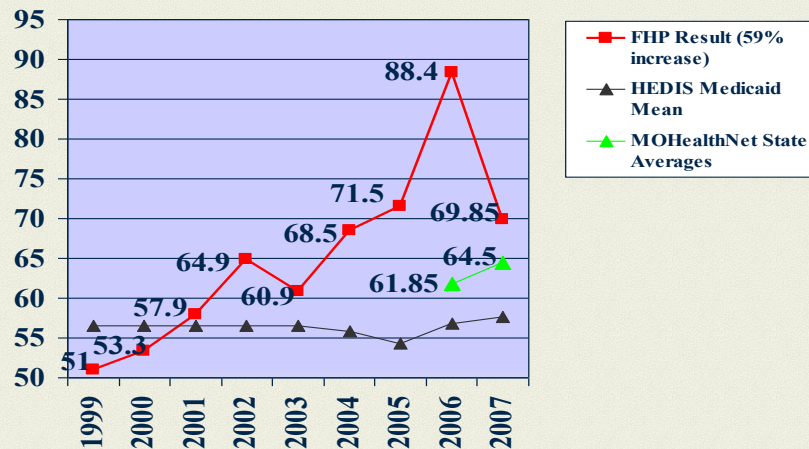
Timeliness of Prenatal Care

Postpartum Care

Annual Dental Visits*

Legend:
- FHP Results (.2% increase)
- HP 2010
- HEDIS Medicaid Mean
- MOHealthNet State Averages

Data points (FHP Results): 1999: 37.45, 2000: 34.77, 2001: 36.95, 2002: 36.29, 2003: 40.43, 2004: 39.1, 2005: 40.43, 2006: 38.59

HEDIS Medicaid Mean values: 36.7, 40.94

MOHealthNet State Averages: 31.4, 27.54
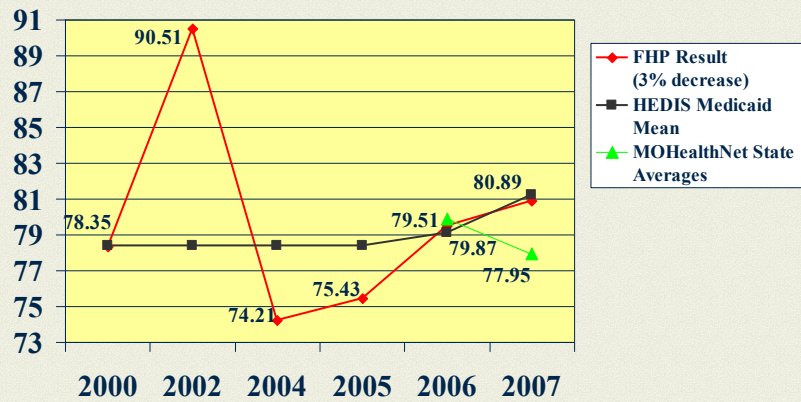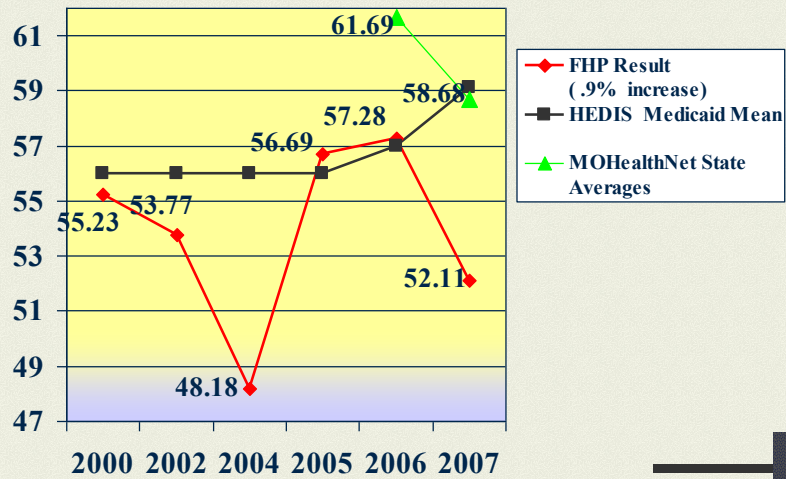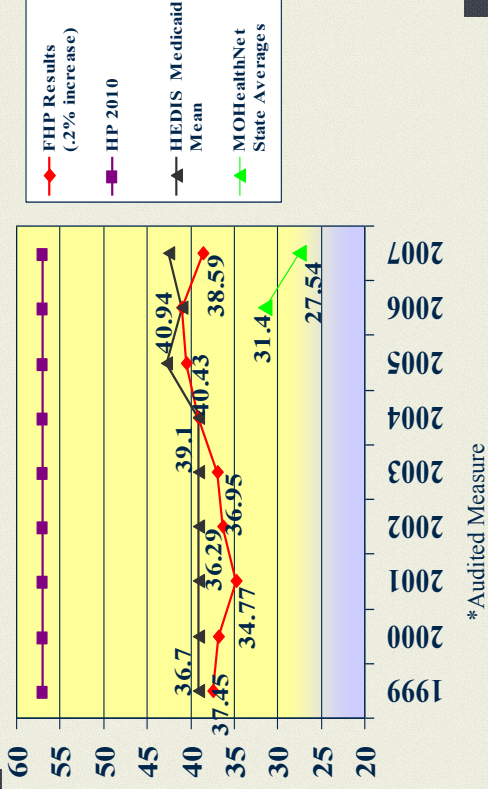
*Audited Measure

Six or More Well Child Visits in 1st 15 months of Life

Legend:
- FHP (240% increase)
- HEDIS Medicaid Mean
- MOHealthNet State Averages

Data points (FHP): 2003: 37.58, 2004: 23.91, 2005: 34.72, 2006: 62.03, 2007: 66.75

HEDIS Medicaid Mean: 51.24

MOHealthNet State Averages: 57.8

72

Well Child Visits 3-6 years

Legend:
- FHP Result (41% increase)
- HP 2010
- RFP Target
- HEDIS Medicaid Mean
- MOHealthNet State Averages

Data labels: 55.37, 49.55, 48.8, 46.5, 47.8, 56.3, 72.75, 66.3, 62.53, 51.7, 53.69

23

Adolescent Well Care*

Legend:
- FHP Result (19% increase)
- HP 2010 Target
- RFP Target
- HEDIS Medicaid Mean
- MOHealthNet State Averages

Data labels: 38.86, 32.79, 32.33, 30.3, 32.9, 33.1, 33.1, 35.6, 42.82, 41.61, 33.41

*Note HEDIS Measure different from periodicity schedule

*Audited Measure

24

73

Ambulatory Care
(ER Visits/1000mbrs)

Legend: FHP Results (52% increase); HEDIS Medicaid Mean

Data points (FHP Results): 59.56, 54.87, 60.62, 61.41, 77.93, 80.71

X-axis: 2001 2002 2004 2005 2006 2007

1

Ambulatory Care
(Out patient visits/1000mbrs)

Legend: FHP Results (35% increase); HEDIS 2007 Medicaid Mean

Data points (FHP Results): 235.92, 296.79, 365.29, 370.9, 337.25, 338.94

X-axis: 2001 2002 2004 2005 2006 2007
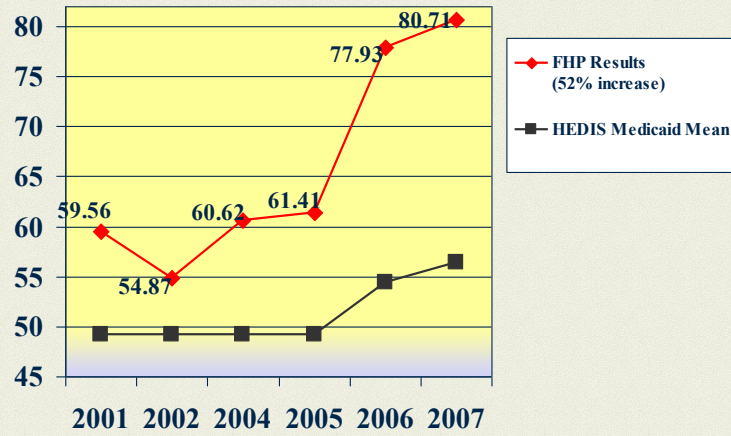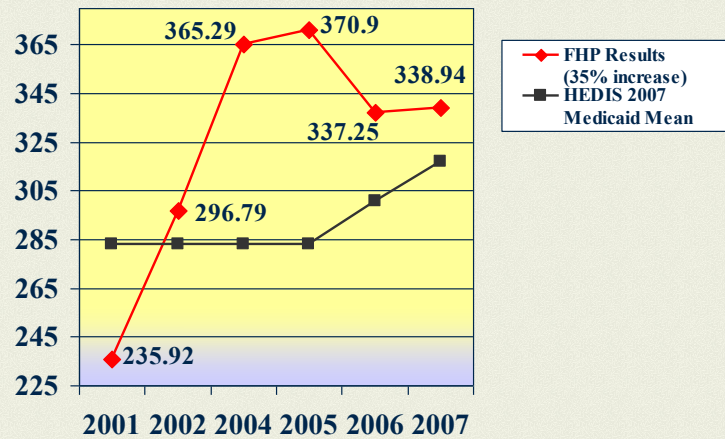
26

Ambulatory Care
(Amb Surg Proc/1000mbrs)

Legend:
- FHP Results (26% increase)
- HEDIS 2007 Medicaid Mean

Data points (FHP Results): 3.64 (2001), 3.42 (2002), 4.29 (2004), 4.67 (2005), 4.71 (2006), 4.05 (2007)
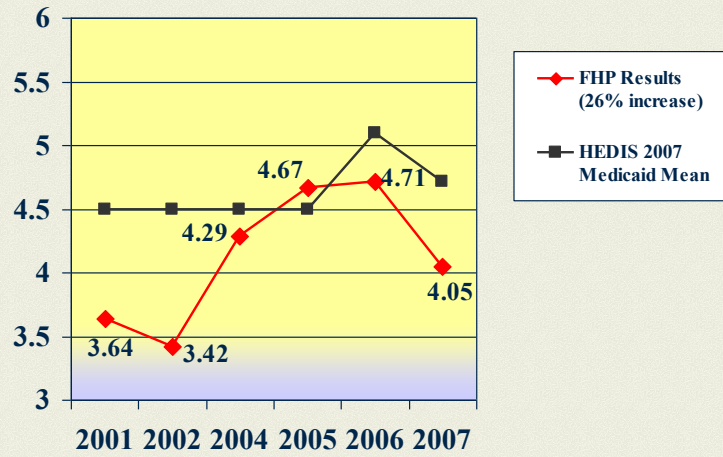
27

Mental Health Utilization
Any MH Service

Legend:
- FHP Result (93% increase)
- HEDIS Medicaid Mean

Data points (FHP Result): 4.82 (1999), 4.54 (2000), 5.39 (2001), 6.95 (2002), 7.82 (2003), 8.3 (2004), 8.46 (2005), 7.53 (2006), 8.3 (2007)
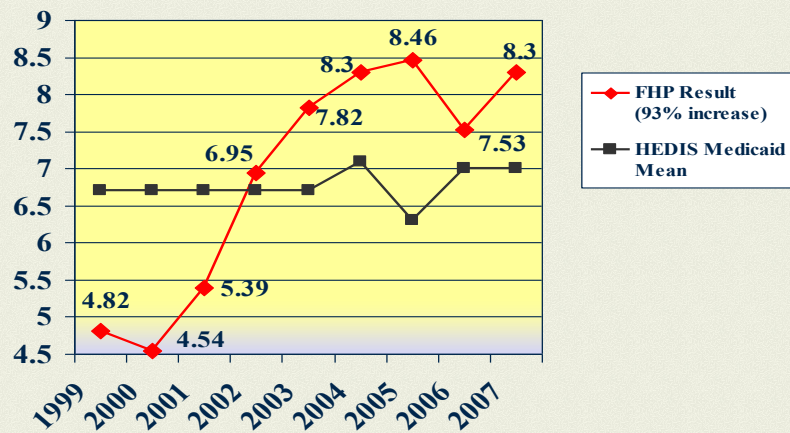
28

Identification of Alcohol and Drug Services - Any AD Service
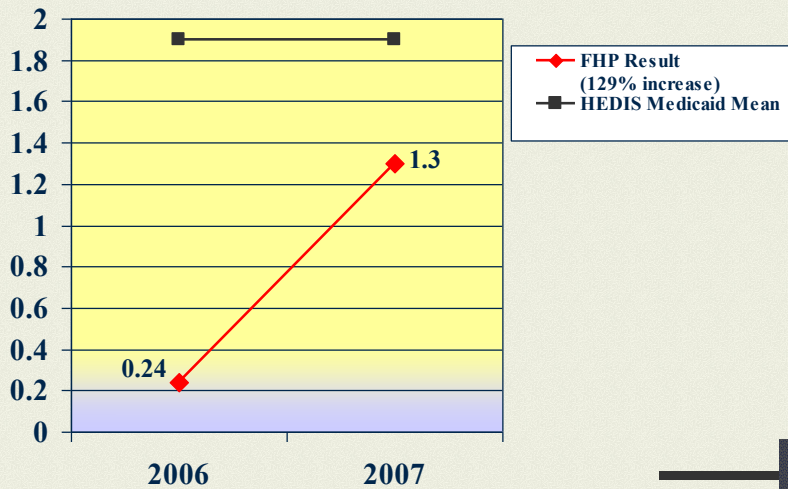
Trends in MO HealthNet Quality Indicators
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

The Department of Health and Senior Services calculates and reports Maternal and Child Quality Indicators based on data from birth certificate information. Opportunities for improvement are discussed and evaluated.

Improvement initiatives implemented based on Children's Mercy Family Health Partners' Maternal-Child indicator results included:
- Outreach to members and providers to increase the rate of prenatal care initiation in the first trimester of pregnancy,
- Targeted OB Education to high volume provider offices to increase the rate of prenatal care initiation in the first trimester of pregnancy and notification to the health plan for assessment and case management services,
- Continued targeted OB case management to outreach to high risk pregnant women for improved birth outcomes.

Please see the following graphs for demonstration of Children's Mercy Family Health Partners tracking and trending of maternal child indicators.

CMFHP Maternal Health Indicators
Percent of Women With Prenatal Care
(Based on DHSS Data - Total deliveries =Total live births to women with know prenatal care)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of Women Receiving Early Prenatal Care
(Based on DHSS Data - Total deliveries=Total live births to continuously enrolled women for 280 days prior to delivery)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of Prenatal WIC Participants
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of Repeat Births to Women <20 years
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
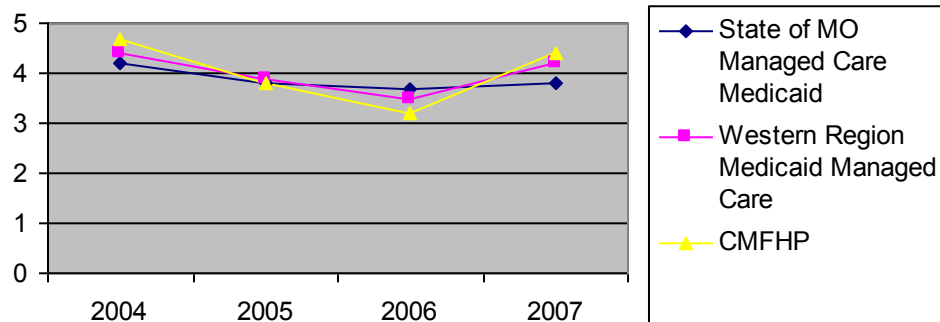
CMFHP Maternal Health Indicators
Percent of Births to Women <18 years
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
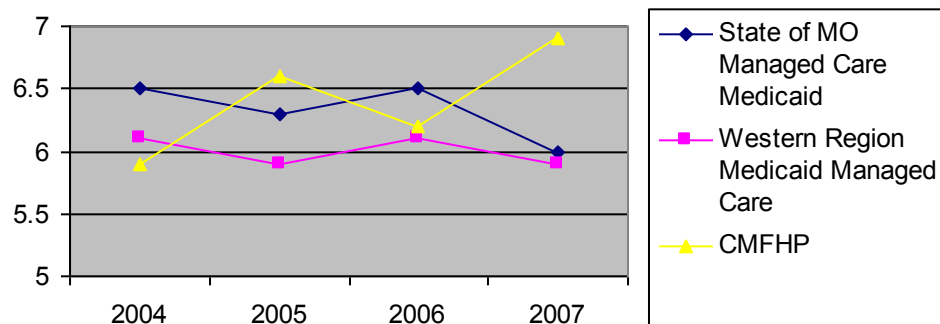
CMFHP Maternal Health Indicators
Percent of Women with Birth Spacing <18 Months
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP
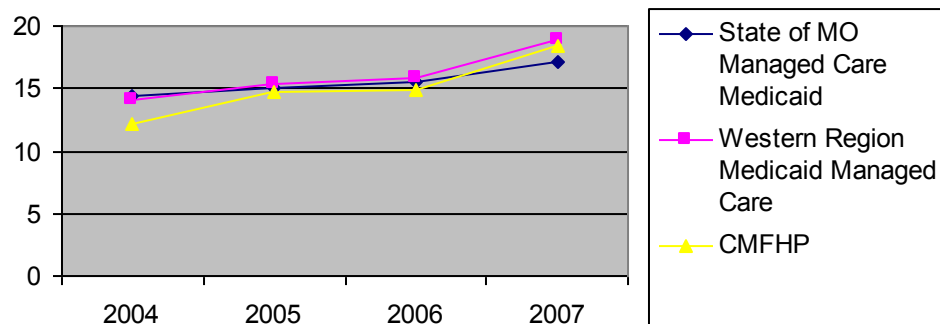
CMFHP Maternal Health Indicators
Percent of Women Smoking During Pregnancy
(Based on DHSS Data)
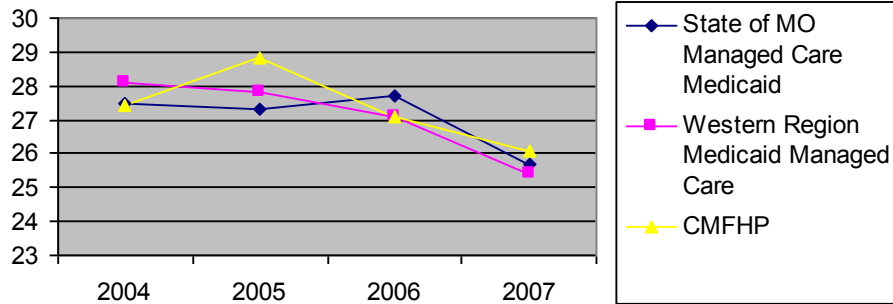
CMFHP Maternal Health Indicators
Cesarean Section Deliveries
(Based on DHSS Data)
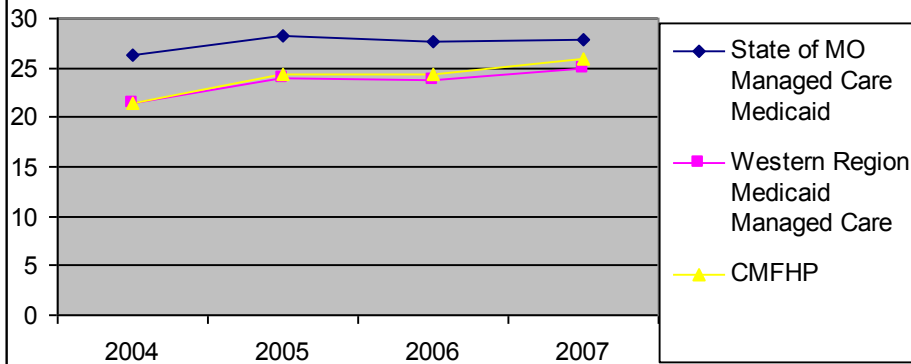
CMFHP Maternal Health Indicators
Vaginal Deliveries After C/S
(Based on DHSS Data)

79

CMFHP Maternal Health Indicators
Percent of Low Birth Weight Deliveries (<2500 Grams)
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Health Indicators
Percent of LBW Deliveries in Level II/III Hospitals(<2500 Grams)
(Based on DHSS Data)

Legend:
- State of MO Managed Care Medicaid
- Western Region Medicaid Managed Care
- CMFHP

CMFHP Maternal Child Health Indicators
Percent of VLBW (Infants <1500 Grams)
Delivered in Level II/III Hospitals
(Based on DHSS Data)

Legend:
- State Medicaid Manged Care
- Western Region
- CMFHP

Children's Mercy Family Health Partners (CMFHP) has created a Corporate Dashboard for FY 2008. The indicators are identified by each department as pertinent and representative of their activities. The dashboard is reviewed quarterly by the Administrative Oversight Council. This report can be found at Attachment 16.

Harmony Health Plan of Missouri

Performance Measures
In an effort to support MO HealthNet quality initiatives, ensure network quality compliance, improve overall plan satisfaction and support network relationships, provider and member outreach activities continue to be focused upon achieving statistically significant HEDIS results in a minimum of 33% of HEDIS measures with a focus on achieving the 75th percentile of Quality Compass National Reporting.

Additionally Harmony Health Plan supports ―MO HealthNet Managed Care Performance Measures" in measures that specifically represent the HHP MO HealthNet population demographic. Targets for monitoring and strategies for improvement include the following measurements:

> Childhood Immunization Status
> Cervical Cancer Screening
> Chlamydia Screening in Woman
> Follow-up After Hospitalization for Mental Health Disorders
> Use of Appropriate Asthma Medications for People with Asthma
> Peri-natal and Postpartum Care
> Annual Dental Visits
> CAHPS Child and Adult Survey
> Well Child Visits in the First 15 Months of Life
> Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
> Adolescent Well Care Visits
> Ambulatory Care
> Mental Health Utilization-Percentage of Members Receiving Inpatient,
> Intermediate Care and Ambulatory Services
> Identification of Alcohol and Other Drug Services

Because opportunities for improvement remain in all measures HHP provides educational outreach activities through Newsletters, Provider Pay for Quality Program (initiated June, 2008), contracting with additional OB/GYN specialist, partnerships through collaborative efforts with FCM/WIC, Maternal Child Family Health Coalition and The St. Louis Regional Asthma Consortium, Hugs Peri-natal outreach program, Disease and Case Management, posters, brochures, community outreach, periodicity letters and noncompliant member list of members in need of preventive services.

Childhood Immunization Status

	DTP	MMR	IPV OPV	HIB	Hep B	VZV	Pneumo-coccol conju-gate	Combo 3	Combo 2
HEDIS 2007	36.36%	70.45%	52.27%	56.82%	56.82%	63.64%	36.36%	27.27%	34.09%
HEDIS 2008									
HEDIS 2009									
HEDIS 2010									

The Childhood immunization rates appear to indicate low numbers, however upon more detailed review of data the health plan discovered that many members were actually receiving immunizations. Immunizations were received by members beyond the dates recommended in the HEDIS Technical Specification guidelines, sometimes by a day or two. Significant opportunities for improvement exist with this measure. The Quality nurses continue to reach out to providers and their offices reminding them of the importance of obtaining past medical records and immunization records, turning missed opportunities into opportunities for immunization, and providing them with current CPT /ICD9 codes, lists of members needing services, and report cards on how well each provider is doing in reaching the members needing services.

Cervical Cancer Screening

Cervical Cancer Screening	Reported Rate
HEDIS 2007	40.20%
HEDIS 2008	
HEDIS 2009	
HEDIS 2010	

Cervical Cancer Screening
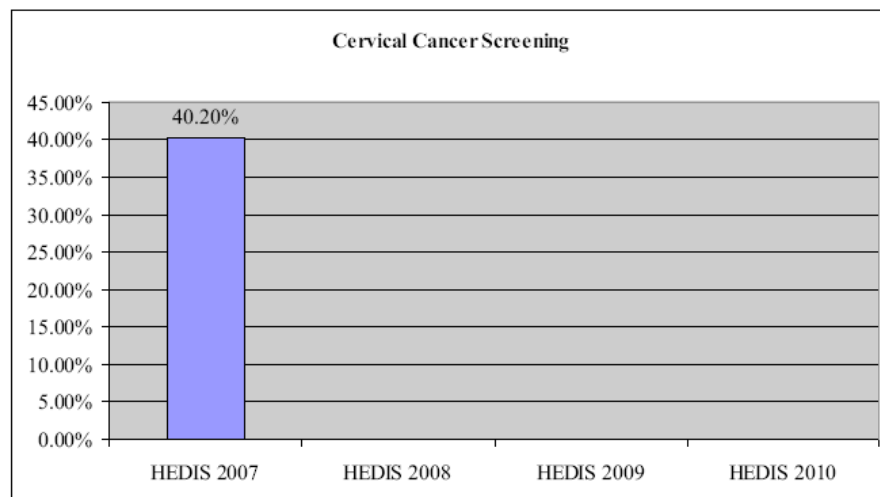
The quality improvement staff has completed medical record reviews in provider offices to determine if educational opportunities relative to the Cervical Cancer screening measure existed with members and/or providers. The health plan noted that many providers were completing cervical cancer screenings however there may be some questions with coding of claims and encounters with the state lab. These issues were identified by two other MO HEALTHNET plans. HHP will be participating in a task force to identify if the codes used may have caused discrepancies in the data reported. Further data analysis will be needed on the part of HHP to identify if this problem existed with their members.

The Quality nurses continue to reach out to providers and their offices reminding them of the importance of obtaining past medical records, turning missed opportunities into opportunities for preventive services, and providing them with current CPT /ICD9 codes, lists of members needing service, and report cards on how well each provider is doing in reaching the members needing services.

Follow-up after Hospitalization For Mental Health Disorders

Post Hospital Discharge Follow-up:

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Follow-UP										
DSCHG w OTPT F/U CP	4	3	5	2	0	0	3	4	1	2
# INPT DC Excluded	0	2	1	0	0	0	1	1	0	1
# OTPT TX within 7D	0	0	1	0	0	0	1	2	0	0
% F/U in 7D	0%	0%	20%	0%	0%	0%	33%	50%	0%	0%
# OTPT TX within 30D	0	1	0	1	0	0	2	3	1	1
% F/U in 30D	0%	33%	0%	50%	0%	0%	67%	75%	100%	50%

Interventions implemented to impact follow-up rates:

- Reconfigured staff resources to dedicate 1 FTE to work with members and providers to enhance discharge plans and follow through with outpatient treatment plans in Missouri

- Coordinated case management for every Missouri admission involving the HBH case manager and the HBH discharge coordinator. This included case conferences on each Missouri admission to update discharge plan daily

- HBH outpatient care managers will authorize multiple H2H sessions on the front end for those patients identified as high risk to provide in home services until the member is linked with outpatient treatment

- The discharge coordinator assists with coordination and referral for transportation Services

- The HBH QI Analyst reached out to H2H providers to ensure linkage between member, facility and provider.

- HBH reached out to facilities and trained UM staff on follow-up protocols and provided H2H brochures

- HBH Medical Director conducted conference calls with providers to enhance coordination of follow-up for members

Use of Appropriate Asthma Medications for People with Asthma
Due to insufficient numbers of members with asthma to meet NCQA guidelines for reporting data, data was not collected for this measure.

Even though HEDIS numbers were not reported on asthma, Harmony Health Plan realizes the burden of asthma on members. The Quality Nurses participate in the St. Louis Regional Asthma Consortium. They work with providers informing them of current asthma guidelines. They have provided education throughout the community, have partnered with The American Lung Association with planning and participating in the annual Asthma Walk, and have also served on a planning committee for education of children and families at asthma camp. One of the health team members is a certified asthma educator who has received an award for being the American Lung Association 2007 Lung Health Hero for volunteering and championing community education on asthma. Further to this end, Harmony's Executive Director serves on the Leadership Board for the American Lung Association.

Accessibility of Care
Prenatal and Postpartum Care

HEDIS MEASURE	Final Rate 2006	Final Rate 2007
PRENATAL/PP CARE		
Timeliness of Prenatal Care	85.29%	86.51%
Postpartum Care	47.06%	55.56%

In regards to post partum care; the health plan has not reached its goal of 80% compliance. HHP is continuing to strive towards its goal by enhancing the Harmony Hugs perinatal outreach program. A cause/barrier analysis shows that low post partum rates may be due to the following factors: Discharge planning instructs women to go to post partum visit before the HEDIS designated time frame of 3-8 weeks after date of delivery. During HEDIS chart chases, HHP quality staff found that women are completing post partum follow up visits but dates are outside the HEDIS timeframe requirements. HHP also encountered difficulty confirming where members received postpartum care.

From July 1, 2007 until June 30, 2008 the Hugs program has:
- Enrolled a total of 138 members in the state of MO
- Of the members enrolled in MO, 15 were High Risk, 46 were Moderate Risk, and 77 were Low Risk
- Harmony Hugs has increased participation rates tremendously:
  o From Jan-June of 2007 the Harmony Hugs program enrolled a total of 18

women into the Hugs program. From Jan-June of 2008 Harmony Hugs had increased participation by having enrolled 120 women into the Hugs program for the first half of the year.

- There have been 107 deliveries of Harmony Hugs participants of which only 6 had a birth weight below 2499 grams

Annual Dental Visits

HHP	2-3 yrs old	4-6 yrs old	7-10 yrs old	11-14 yrs old	15-18 yrs old	19-21 yrs old	combined
HEDIS 2007	3.69%	19.93%	25.93%	16.55%	16.67%	9.41%	16.94%
HEDIS 2008							
HEDIS 2009							
HEDIS 2010							

Harmony Health Plan realizes there are opportunities to increase the low numbers of members receiving dental care. Realizing the importance of good dental hygiene for members and the effects of poor dental hygiene on health, Harmony Health Plan has initiated several programs to educate and encourage members to participate in receiving dental care. Education is provided at community events on the importance of dental care. Providers of medical care are reminded and encouraged to refer and encourage members to receive dental care.

In community outreach Harmony Health plan has implemented a Harmony Smiles Program. The program is a collaborative effort with Bridgeport Dental. Harmony Smiles Dental Program is presented during the month of February to acknowledge National Dental Month. The program is designed for pre-kindergarten through second grade students. Each student is presented with a dental grab bag filled with everything from a coloring sheet to a brand new toothbrush. We shared the Harmony Smiles Dental program with over 3,400 students throughout the St. Louis Metro East area.

Satisfaction With The Experience of Care

CAHPS 3.0 OH Child/Adult Survey

2008 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS SURVEY (CAHPS)

Results – Harmony Health Plan of Missouri utilized an NCQA approved CAHPS member satisfaction survey. This was the first year that a CAHPS survey was implemented.

This survey was conducted using mixed (mail and telephone) survey administration methodology (following NCQA protocol). The Myers Group (TMG) collected 140 valid surveys

from the eligible member population from January through May 2008, yielding a response rate of 8.7% for the 2008 Child Member Satisfaction Survey. For the 2008 Adult Member Satisfaction Survey TMG collected 115 completed surveys from the eligible member population from January through May 2008, yielding a response rate of 9.1%.

The member satisfaction scores were compared to national benchmarks. The Medicaid Child Member Satisfaction survey was compared to the 2007 CAHPS Booklet. The Medicaid Adult Member Satisfaction Survey scores were compared with the Quality Compass 2007 (Public Report). The summary rates for the Medicaid Child composite measures are below the 25th percentile when compared to the 2007 CAHPS Booklet. The summary rates for the Medicaid Adult composite measures are below the 10th percentile when compared to the 2007 Quality Compass.

Areas of Opportunities are noted below:

Medicaid Child Composite/Attribute/Rating Item	2008 Plan Summary Rate	2007 CAHPS Booklet (Medicaid Child) Mean	2007 CAHPS Booklet (Medicaid Child) 90th Percentile
Getting Needed Care	**67.5%**	**80.7%**	**85.6%**
Q7. Getting a provider you are happy with	61.1%	78.2%	NA
Q10. Seeing a specialist	46.9%	67.6%	NA
Q25. Getting care, tests, or treatments necessary	70.4%	82.6%	NA
Getting Care Quickly	**68.9%**	**78.1%**	**86.0%**
Q15. Getting the help/advice you needed	77.3%	85.5%	NA
Q17. Obtaining care right away for an illness/injury/condition	72.6%	87.4%	NA
Q20. Obtaining care when wanted, not when needed right away	75.6%	84.5%	NA
Rating of Personal Doctor (Q5)	**73.0%**	**81.5%**	**88.0%**
Rating of Health Care (Q39)	**67.6%**	**81.0%**	**87.4%**
Rating of Health Plan (Q62)	**71.2%**	**79.5%**	**87.5%**

Medicaid Adult Composite/Attribute/Rating Item	2008 Plan Summary Rate	2007 Quality Compass (Mean)	2007 Quality Compass (90th Percentile)
Getting Needed Care	**57.1%**	**75.5%**	**83.0%**
Q23. Ease of getting appointment with a specialist	48.1%	74.0%	82.1%
Q27. Getting care, tests, or treatments necessary	66.0%	77.7%	84.6%
Getting Care Quickly	**69.0%**	**79.6%**	**85.1%**
Q4. Obtaining needed care right away	78.0%	80.9%	86.4%
Q6. Obtaining care when needed, not when needed right away	60.0%	78.7%	84.9%
Rating of Personal Doctor (Q21)	**67.3%**	**76.5%**	**81.8%**
Rating of Health Care (Q12)	**68.6%**	**66.3%**	**72.6%**
Rating of Health Plan (Q35)	**63.2%**	**70.7%**	**78.5%**

Getting Needed Care composite measures the experiences member had in the last six months when attempting to get care from doctors and specialist. Getting Care Quickly measures members' experiences with receiving care and getting appointments in a reasonable time. These two measures can affect how the member rates their doctor and the health plan. The Rating of the Person Doctor and the Rating of the Health Plan are important indicators of plan quality. So by

identifying the barriers and developing interventions to address these measures the overall satisfaction of the members will increase and in turn will increase the Rating of Personal Doctor, Rating of the Health Plan and the Rating of Health Care.

The following interventions were initiated in the Fourth Quarter of 2008:

Health Plan Level Interventions
- Analyze provider network through GEO access review, identified member to provider ratio by specialty and then by zip code.
- Identify service utilization patterns in specific zip codes to further identify potential access issues.
- Increase targeted contracting efforts with PCPs and OB/Gynes in zip codes with noted deficiencies.

Provider Level Interventions
- Increase one on one Provider education sessions and reinforce specific access and availability parameter action items and referral process to specialists.
- Educate IPA on potential referral/specialist issues.
- Update access and availability standards in the Provider Manual.
- Publish access and availability standards in provider newsletters.
- Update clinical practice guidelines and publish accordingly.

Member Level Interventions
- Publish modified version of referral process in the member newsletter.
- Addition of custom question(s) to the 2009 Adult CAHPS survey based on recommendations from The Myers Group. Custom questions can help "drill down" into the causes of specific performance problems for a more detailed analysis.
- Utilization of website for access to Plan offering and provider directories is pending analysis.
- Enhanced transition of care and coordination of care processes to assist new members with continuity of care is being received well by new members.
- Updated new member packets, member manuals, and member newsletters improve communication of benefits and information. Efficacy measurement is pending.
- Telephonic satisfaction survey participation is not statistically significant at this time. Members are being encouraged to access the survey when opportunity permits.

Once areas of opportunities were identified from the 2008 CAHPS survey rates a Performance Improvement Project (PIP) was implemented to aid in the analysis of data, development of interventions, and tracking of improvement over time. The goal of this PIP is to improve member satisfaction and quality of care by improving access and availability. Improving access and availability will have a direct positive impact on the overall rating of the member's doctor, health care, and health plan. The 2008 CAHPS survey rates will serve as the baseline rates for the PIP.

Use of Services
Well Child Visits in the First 15 Months of Life
The Well Child Visit (0-15months) HEDIS measure is an inverse measure with the intent of decreasing the potentiality that children are not receiving well visits. The Quality improvement

staff completed medical record reviews in provider offices to determine if educational opportunities relative to the well Child Visit measure existed with members and/or providers. The health plan staff noted that although many providers and their staffs were able to verbalize the components of a Well Child Visit their documentation was not adequate to support actual provision of appropriate services.

The Quality Improvement staff continues to reinforce documentation and coding concepts and has presented offices with appropriate documentation forms in an effort to assist the offices with improved documentation and provision of services. In addition through identification of an opportunity for improvement the Quality Improvement staff has developed a Performance Improvement Project (PIP) to provide additional education to provider offices on the proper components of a medical record, needed information, and what services must be completed and accurately documented for our pediatric members. While reviewing the medical records an observation was made that many pediatric members received services shortly after they became 15 months of age. Significant opportunities remain for improvement in this measure.

	0 Visits	1 Visit	2 Visits	3 Visits	4 Visits	5 Visits	6/6+ Visits
HEDIS 2007	11.63%	8.14%	2.33%	9.30%	10.47%	16.28%	41.86%
HEDIS 2008							
HEDIS 2009							
HEDIS 2010							

Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
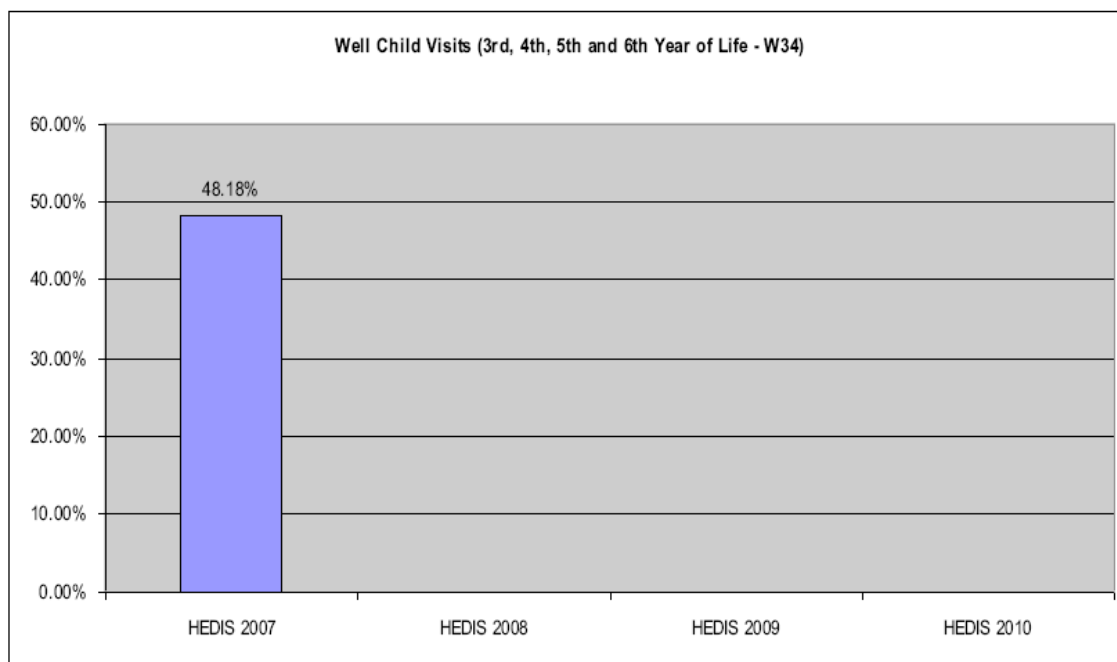
Significant opportunities remain for improvement in this measure in children ages three through six. The Quality improvement staff completed medical record reviews in provider offices to determine if educational opportunities relative to the well Child Visit measure existed with members and/or providers. The health plan staff noted that although many providers and their staffs were able to verbalize the components of a Well Child Visit their documentation was not adequate to support actual provision of appropriate services.

The Quality Improvement staff continues to reinforce documentation and coding concepts and has presented offices with appropriate documentation forms in an effort to assist the offices with improved documentation and provision of services. In addition through identification of an opportunity for improvement the Quality Improvement staff has developed a Performance Improvement Project (PIP) to provide additional education to provider offices on the proper components of a medical record, needed information, and what services must be completed and accurately documented for our pediatric members.

Adolescent Well-Care Visits
The Quality improvement staff work through the collaborative Adolescent Well Child Visit Performance Improvement Project to help increase adolescent well care visits for all adolescents in Missouri including Harmony Health plans members.

The Quality improvement staff completed medical record reviews in provider offices to determine if educational opportunities relative to the well Child Visit measure existed with members and/or providers. The health plan staff noted that although many providers and their staffs were able to verbalize the components of a Well Child Visit their documentation was not adequate to support actual provision of appropriate services. The Quality Improvement staff continues to reinforce documentation and coding concepts and has presented offices with

appropriate documentation forms in an effort to assist the offices with improved documentation and provision of services. In addition through identification of an opportunity for improvement the Quality Improvement staff has developed a Performance Improvement Project (PIP) to provide additional education to provider offices on the proper components of a medical record, needed information, and what services must be completed and accurately documented for our pediatric members.

In addition targeted messages were provided through newsletters to providers and members. Education to providers includes reminders of components of a well child visit, forms for documentation, and missed opportunities. Participation in events with the St. Louis City School Nurses providing education to increase their understanding of referrals and opportunities to encourage adolescents to seek well child care.

A Pay for Quality (PFQ) program was initiated in June to further support these services. Significant opportunities remain for improvement in this measure.

	Adolescent Well Care Visits (AWC)
HEDIS 2007	25.06%
HEDIS 2008	
HEDIS 2009	
HEDIS 2010	

Ambulatory Care

Ambulatory Care (AMB) Measurement Year: 2007

Age	Member Months
<1	8227
1-9	27843
10-19	22030
20-44	15901
45-64	954
65-74	0
75-84	0
85+	0
Unkown	0
Total	74955

Age	Outpatient Visits		ED Visits		Ambulatory Surgery Procedures		Observation Room Stays Resulting in Discharge	
	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Procedures	Procedures/1,000 Member Months	Stays	Stays/1,000 Member Months
<1	3307	401.97	1048	127.39	21	2.55	7	0.85
1-9	3379	121.36	1871	67.20	42	1.51	5	0.18
10-19	2702	122.65	1128	51.20	25	1.13	23	1.04
20-44	4766	299.73	1610	101.25	79	4.97	102	6.41
45-64	226	236.90	60	62.89	2	2.10	3	3.14
65-74	0	NA	0	NA	0	NA	0	NA
75-84	0	NA	0	NA	0	NA	0	NA
85+	0	NA	0	NA	0	NA	0	NA
Unkown	0		0		0		0	
Total	14380	191.85	5717	76.27	169	2.25	140	1.87

Harmony Health Plan reviews trending, over utilization and under utilization reported through the QIC meetings. In addition provider visits by the health Service team (Medical Director and/or the Quality nurses) reviews individual provider's rates of utilization with the larger providers. Education is provided to the providers for use of Observation days when appropriate.

Emergency room visits are tracked and reported through the QIC as well. Providers are notified of members who have multiple visits to the Emergency room per quarter. Providers are encouraged to reach out to their members and encourage them to follow up and receive services with their PCP. In addition HHP has a brochure that is available to members and explains appropriate use of the Emergency Room and alternatives.

Harmony Health Plan has an Emergency Room Program that stratifies members by utilization rates of Emergency Room Services, and has interventions based on the stratification process and quantitative rate of ER use by the member reported per quarter. HHP attempts to reach out to members both telephonic and through mail. When a member is reached, education is provided on the appropriate use of the Emergency Room, alternatives for care, and the Nurse Triage line. If a chronic disease or condition is identified as well as social problems representing barriers to care, members are encouraged to participate in disease management or case management programs.

HHP reaches out to members attempting to identify and resolve all barriers by changing PCP's as necessary or attempting to resolve any other issues identified as barriers to receiving care from the members primary care provider.

The largest barrier to the Emergency Room Utilization Program is the inability to reach members. The transient nature of the members presents challenges to the plan to reach the members both telephonically and through mail. Great opportunities remain for both the plan and the state to identify ways to better track and have accurate information to reach members.

Mental Health Utilization – Percentage of Members Receiving Inpatient, Intermediate Care, and Ambulatory Services (MPT)

Membership	7,669	8,581	9,757	10,500	11,234	12,456	11,253	11,649	12,044	12,095
Partial D/N TX	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
# Admits	0	2	3	0	0	0	0	0	0	0
Days/1000 Members	0	2.8	3.69	0	0	0	0	0	0	0
# of Days of Care	0	3	3	0	0	0	0	0	0	0
Days/1000 Members	0	4.2	3.69	0	0	0	0	0	0	0
Average LOS	0	1.5	1	0	0	0	0	0	0	0
Intensive OTPT										
# of OTPT"s	0	1	1	0	1	0	1	2	1	0
OTPT's/1000 Members	0	1.4	1.23	0	1.07	0	1.04	2.06	1	0
# Days of Care	0	10	10	0	11	0	12	25	18	0
Days/1000Members	0	13.98	12.3	0	11.75	0	12.5	25.75	17.93	0
Average LOS	0	10	10	0	11	0	12	12.5	18	0
OTPT TX										
# OTPTS	1	4	3	1	69	70	94	96	71	69
OTPTS/1000Members	1.56	5.59	3.69	1.14	73.7	67.4	97.9	98.9	70.7	68.5
# OTPT Visits	3	30	8	10	95	105	153	124	110	114
Days/1000 Members	4.69	41.95	9.84	11.43	101.5	101.2	159.3	127.7	109.6	113.1
Average # Visits	3	7.5	2.7	10	1.4	1.5	1.6	1.3	1.5	1.7

Outpatient Utilization Management:
We do not require prior authorization for outpatient visits, but analyze outlier reports on a quarterly basis. The data for outpatient treatment is claims based and the providers have 180 days to submit claims. This lag in submission of claims by providers explains the low numbers reflected in this report for September, October, November, and December of 2007. The average number of visits per member for MO HealthNet members remained fairly consistent between 1.3 and 1.7 from January 2008 through June 2008.

Identification of Alcohol and Other Drug Services
MO Annual Evaluation 9/1/2007-June 30, 2008
Key Accomplishments

❖ The ICM Team developed the structured BH Comprehensive Case Management Assessments and Problems-Goals-Interventions Care Plans, and they were embedded in EMMA, the new, fully integrated medical management information system. The Team served as ―Test pilots" in EMMA in first quarter 2008. Structured comprehensive behavioral health case management assessments and individualized, specific case management care plans are embedded in the system, which allows a organized, focused, member-centric approach to member care management. EMMA allows fully integrated medical and behavioral case management, as all assessments, care plans, and case notes completed by the health plan case and disease managers, pharmacy, utilization management and BH ICM Care Management are transparent. Effective the end of second quarter, the entire ICM Team was working in EMMA.

❖ In the fourth quarter of 2007, the Health Plan Disease Management Programs implemented behavioral health screening into their overall member health risk screening that is provided to all newly enrolled members.

❖ The three screens utilized are for depression, post partum depression, and substance abuse. Those members identified as having BH conditions or significant symptoms stratified for either referral to BH Intake for referral and linkage to BH providers, or to BH Triage for further assessment, or to the BH ICM Program if criteria are met.

❖ Led the initiative to develop workflows for MO members identified as having substance abuse disorders and treated in inpatient detoxification. The initiative involved the offer of ICM/MBCM to those who meet criteria and the offer of behavioral health coordination of care services to those who do not meet criteria for ICM/MBCM but are in need of follow-up active substance abuse treatment following inpatient detoxification.

❖ A workflow was developed in fourth quarter of 2007 and an ICM Team *C-STAR and HUGS*-dedicated Case Manager was selected for successful collaboration with the MO state-mandated C-STAR and the *Harmony HUGS* program, both of which target women with pregnancies and identified substance abuse and mental health presenting problems.

❖ Health Plan Case Coordinators and Case Managers screen women who are perinatal or postpartum, using the Edinburgh Postnatal Depression Scale to screen for depression and risk for postpartum disorders. Members with positive scores are referred to the HBH ICM or MBCM Programs as indicated by presenting conditions.

❖ During the second quarter of 2008, selection criteria for the ICM Program were revised so that they are evidence-based and likely to target those members at risk for readmission to higher levels of care and for poor behavioral health outcomes.

X. . Intensive Case Management/Medical Behavioral Case Management

The Intensive Case Management Program (HBH ICM Program) is a program for managing care of members who have had, or are likely to have a significant negative change in their mental health status that could be positively impacted by intervention in excess of that afforded by the traditional care management utilization review process. The ICM program targets select at-risk populations and focuses on clinical and social service solutions for members who may require greater levels of assistance because of the severity, complexity and duration of their behavioral conditions. ICM Care Managers engage members and their supports to develop solutions for problems within the member's system of support and care. ICM Care Managers coordinate activities across all levels of care to avert the need for hospitalization, re-hospitalization or prolonged intensive behavioral health care services, and to improve patient health-related quality of life and overall life functioning.

Members enrolled in the HBH ICM Program may be identified at any point in their interaction with HBH, including at initial intake, during acute care episodes in facilitybased care, or following discharge from facility-based care. The process of identifying members for the ICM Program involves a comprehensive review of risk criteria by the clinical team. The ICM program

is designed to be dynamic and fluid: selected members are assigned to the ICM program are provided intensive management until they achieve functional stability and increased community tenure, and are then transitioned out of the program where they will be followed as needed through the standard HBH care management process.

The Medical-Behavioral Case Management Program (MBCM) is a uniquely structured program which provides integrated medical and behavioral case management services for health plan members with complicated medical and behavioral health conditions. Multidisciplinary coordination of medical and behavioral health care services is achieved through paired assignments of skilled clinical care managers from WellCare's operationally integrated medical and behavioral care management units.

The objective of the MBCM program is to improve the quality of care delivered to members with coexisting psychiatric and medical disorders through increased access to needed behavioral health services and reduced avoidable medical costs associated with untreated psychiatric conditions. Experience in direct care and managed care settings have consistently demonstrated the value of coordination of services for persons with significant medical and psychiatric conditions. The presence of co-morbid medical and psychiatric conditions leads to greater morbidity and burden of disease, overall utilization of healthcare resources, and mortality. Co-existing conditions also significantly affects functional capacity and quality of life for both patients and their family members. Numerous published studies have shown that coordinated intervention among medical and behavioral health care delivery systems can significantly improve desired clinical and economic outcomes.

The MBCM Program offers coordination of care for members who might otherwise have fragmented care or unrecognized and thus untreated condition(s) leading to unnecessary utilization of health care services. The MBCM Program emphasizes the importance of coordination with primary and specialty care physicians, behavioral health and allied health providers, and community social service agencies to maximize positive clinical outcomes and improve health related quality of life.

The 2007 ICM/MBCM goals were as follows:
- Reduce overall readmission rates by 5%.
- Reduce overall health care costs of ICM members by an average savings of $3,000 / 6 month interval post ICM enrollment.
- Develop additional outcome measures for ICM program to measure impact.
- Develop and evaluate caseload thresholds for ICM staff. Maintain case load of 30-40 cases per ICM care manager.
- Expand partnership with Health Services to increase referrals to ICM and MBCM programs and increase medical-behavioral integration outcomes for our members.

Additional ICM/MBCM measurable objectives in 2008 are as follows:
- Increase days in community without acute care readmissions post-ICM
- Implement evidence-based selection criteria for the ICM Program.

Significant accomplishments for the ICM/MBHO programs:
In the fourth quarter of 2007, the [Medical] Disease Management Programs implemented behavioral health screening into their overall member health risk screening that occurs at enrollment of new members or when

a) Depression Screening:
The PHQ-9 is a widely validated tool used by practitioners and managed care organizations for screening of depression. Nationally-developed protocols have been developed to utilize the PHQ instrument to determine the most appropriate course of treatment, relative to severity of a patient's depression, and to monitor ongoing care. The PHQ-2, which is initially administered, includes the first two items [of the PHQ- 9] as the initial screening. If the member responds affirmatively to either of these two items, the member is queried about the remaining seven (7) items. This approach is considered by many organizations to be an efficient way to screen large numbers of patients for purposes of detecting undiagnosed depression in populations.

The PHQ-9 is based upon the diagnostic criteria for Major Depressive Disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). Research has shown that certain scores on the PHQ-9 are strongly correlated with a diagnosis of Major Depressive Disorder. However, every patient with an elevated PHQ-9 is not certain to have Major Depressive Disorder. Therefore, the PHQ-9 is not intended to be a substitute for a face-to-face evaluation and diagnosis by a trained clinician.

b) Post Partum Depression Screening:
The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for post partum depression. The EPDS is easy to administer and has proven to be an effective screening tool. Medical Case Managers administer the EPDS with pregnant members or members who have recently given birth and respond accordingly, depending on the member's EPDS score. A score of ten (10) to thirteen (13), which indicates possible depression, warrants a dialogue with the member to recommend referral to a behavioral health provider for an evaluation. A score of greater than thirteen (13) warrants a referral to the medical-behavioral case management program.

c) Substance Abuse Screening:
The CAGE (alcohol) and CAGE-Aid (drug) are brief screens consisting of four questions that have been shown to effectively identify members who may have a problem with substance abuse. Each affirmative response earns one point. One point indicates a possible problem, which warrants a dialogue with the member to suggest a referral to a behavioral health provider for an evaluation. Two points indicate a probable problem, and is the threshold for referring to Behavioral Health Case Management. Despite its prevalence and the degree to which it complicates health conditions, substance abuse in most patient populations is undiagnosed. The Case and Disease Management programs are in an ideal position to help identify, prevent, and treat substance abuse/dependence by effective screening and intervention.

During Quarter 1, 2008, a partial team of ICM Program Case Managers began working as ―test pilots‖ in the new fully integrated management information system, EMMA. During Quarter 2, the remainder of the team began working exclusively in EMMA, which has structured

comprehensive behavioral health case management assessments and individualized, specific case management care plans embedded in the system. EMMA allows fully integrated medical and behavioral case management, as all assessments, care plans, and case notes completed by the health plan and behavioral health teams are transparent.

Documentation notes in EMMA include completed assessment, individualized care plan, coordination of care with community resources, PCP involvement in aftercare as appropriate, and provision of follow-up services. Member contacts and Case notes are Problems-Goals-Interventions-member response-driven.

In Quarter 2 2008, a non-clinical position was added to the team to process all referrals, complete the initial engagement of members, and complete enrollment in EMMA, which increased efficiency of the team.

Barriers: Program growth was limited by care manager workload capacity and open replacement and new positions. There has been a substantial delay is ability to obtain outcomes data due to waiting periods for increased EMMA functionalities and business analytics staff resources to design and generate reports.

Analysis: The goals for service year 9/1/2007-6/30/08 for MO were to increase enrollment of eligible MO members in ICM/MBCM; to increase our understanding of MO member population characteristics and needs; to increase our understanding of any network or community service gaps that interfere with access to services; and to reduce gaps.

Recommendations for fiscal year 2008-2009 include:
- ❖ Prioritization of both qualitative and quantitative outcome studies to evaluate the effectiveness of the ICM program and to develop action plans to further enhance the program.
- ❖ Develop targeted population-specific protocols of interventions to enhance opportunities for positive outcomes for members with resource allocation to meet the specific challenges of the populations.
- ❖ Continue goal to increase eligible MO members enrolled in both ICM and MBCM by collaborating with HBH Utilization Management Teams and Health Plan Utilization Management and Case and Disease Management to identify eligible members.

I Census, Referrals and Discharge Activity

	9/07	10/07	11/07
Census	0	1	1
ICM	0	1	1
MBCM	0	0	0
Referrals	0	1	0
ICM	0	1	0
MBCM	0	0	0
D/Cs	0	0	0
ICM	0	0	0
MBCM	0	0	0

	9/07	10/07	11/07
C-STAR Coordination Cases:	0	0	0

II. Analysis / Summary:
- 1 member was enrolled in the ICM program at the end of November, 2007
- No members were referred to ICM or MBCM
- No members were discharged from ICM or MBCM

III. Opportunities:
- Continue to identify appropriate candidates for the ICM or MBCM program through collaboration with the Missouri inpatient Care Manager and with Health Services UM and Case Management staff

Effective first quarter 2008, the program began to report MO Members Served by LOB and by Program.

Behavioral Health Intensive Case Management Report
Missouri
January 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	0	0	1	1	2
MMR	0	0	0	0	0
Total	0	0	1	1	2

Behavioral Health Intensive Case Management
Missouri February 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	1	0	1	0	2
MMR	0	0	0	0	0
Total	1	0	1	0	2

Behavioral Health Intensive Case Management
Missouri February 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	1	0	1	0	2
MMR	0	0	0	0	0
Total	1	0	1	0	2

Behavioral Health Intensive Case Management
Missouri March 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	1	0	1	0	2
MMR	0	0	0	0	0
Total	1	0	1	0	2

Behavioral Health Intensive Case Management					
Missouri April 2008 MEMBERS SERVED					
LOB	*ICM*	*MBCM*	*HUGS*	*C-STARS*	*Total*
MMD	0	0	4	0	4
MMR	0	0	0	0	0
Total	0	0	4	0	4

Behavioral Health Intensive Case Management Missouri May 2008					
MEMBERS SERVED					
LOB	*ICM*	*MBCM*	*HUGS*	*C-STARS*	*Total*
MMD	0	0	5	0	5
MMR	0	0	0	0	0
Total	0	0	5	0	5

Behavioral Health Intensive Case Management Missouri June 2008					
MEMBERS SERVED					
LOB	*ICM*	*MBCM*	*HUGS*	*C-STARS*	*Total*
MMD	0	0	5	0	5
MMR	0	1	0	0	1
Total	0	0	5	0	6

Analysis January 1-June 30, 2008
The Missouri membership has ranged from 9,778 in January to 11, 859 in June 2008.
The presentations for psychiatric inpatient level of care on monthly average are less than 10. There is a small, high risk population that appears to drive utilization.

Opportunities: There is opportunity to increase the number of members enrolled in ICM and in MBCM and to select the high risk members. The members who are driving the utilization have the same clinical and other characteristics of members in all states that are at high risk for readmission and poor health and behavioral health outcomes—diagnostically Severely and Persistently Mentally Ill with co-morbid Substance Abuse, low supports, a pattern of non-adherence, lack of meaningful engagement in treatment, and low readiness for change.

Recommendations: Initiate Risk for Readmission Rounds to staff members currently in BHI level of care in order to score risk, identify members for referral to ICM/MBCM; to develop the reducing g risk for readmission plan; and to initiate the interventions when the member is still on the inpatient unit whenever possible.

Trends in MO HealthNet Quality Indicators
HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

Eastern Region Medicaid Baseline vs. Last 57 Months Medicaid MO HEALTHNET

Measure	Before MO HEALTHNET	2003	2004	2005	2006	Jan to Sept 2007
Trimester Prenatal Care Began						
First	70.9%	80.8%	81.0%	82.4%	80.9%	79.4%
Second	23.0%	15.8%	15.3%	14.6%	15.8%	17.3%
Third	3.0%	2.2%	2.2%	1.8%	2.2%	2.4%
None	3.0%	1.2%	1.4%	1.1%	1.1%	0.9%
Inadequate Prenatal Care	27.9%	17.8%	16.7%	15.8%	17.0%	18.3%
Birth Weight						
<500	0.2%	0.3%	0.2%	0.2%	0.2%	0.4%
500-1499	1.7%	1.9%	1.9%	2.0%	1.7%	1.8%
1500-1999	2.3%	2.1%	2.2%	2.3%	2.0%	1.9%
2000-2499	6.7%	6.4%	6.6%	6.7%	6.5%	6.7%
2500+	89.1%	89.3%	89.2%	88.8%	89.6%	89.2%
Low Birth Wt <2500	10.9%	10.7%	10.8%	11.2%	10.4%	10.8%
Method of Delivery						
C-Section	16.3%	26.7%	28.6%	30.0%	30.0%	29.3%
VBAC	36.9%	13.9%	10.7%	7.7%	9.0%	7.7%
Rpt C-Section	63.1%	86.1%	89.3%	92.3%	91.0%	92.3%
Smoking During Pregnancy	26.5%	26.8%	25.9%	25.4%	25.9%	24.5%
Spacing <18 months since last birth	16.9%	14.2%	14.6%	15.8%	15.8%	16.6%

last birth					
Births to moms <18 Y/O	10.6%	6.7%	6.3%	6.1%	6.0%	5.7%
Repeat Teen Births	7.3%	9.7%	7.0%	8.1%	6.8%	5.6%
Fetal Deaths (20+ wks)	8.3%	9.7%	7.0%	8.1%	6.8%	5.6%
Total live Births + Stillbirth fetuses 500 GMS +	193.6	134.6	131.3	149.9	184.9	183.0
% Pre-natals on WIC	75.6%	73.8%	73.1%	72.3%	71.8%	69.9%
VLBW not delivered in Level 3 Hospital	18.7%	11.6%	13.2%	12.5%	8.0%	15.3%
Average Maternal LOS	2.6D	3.0D	3.0D	3.1D	3.1D	3.0D

Harmony Health Plan supports initiatives state wide and internally to identify ways to improve the outcomes of pregnancy.

Through the Harmony Hugs Program every attempt is made to identify and reach out to all pregnant members. Identification of pregnant members is done through pharmacy data for members filling prescriptions for prenatal vitamins, new enrollee's from the state, pregnant members identified through the triage line, self referrals and provider referrals.

A Social Service Specialist works with mothers who want to participate in the Hug's program identifying barriers to care, social issues impacting the pregnancy, and identification of providers and assisting them in getting timely appointments. Research demonstrates early access to prenatal care improves maternal and neonatal outcomes.

The Social Services Specialist provides education on the pregnancy and also information and education on the first year of life and becoming a parent. Peri-natal and postpartum depression screenings are completed and the Social Service Specialist makes appropriate referrals to mental health and medical case management that work together in helping the member to receive mental health and medical services as needed. Early identification of mental health issues and treatment in pregnancy helps to prevent adverse outcomes.

Harmony Health plan has a network in which Level two and Level three hospitals are available in the event of a pregnancy that is high risk or develops unexpected complications.

The Health Service Team participates in the Maternal Child Task Force from the QA&I to identify best practices in the MO HealthNet Managed Care Plans that may help to increase the positive outcomes of pregnancy. Ongoing evaluation of data demonstrates opportunities for improvement. Collaboratively the MO HealthNet Managed Care Health Plans attempt to identify best practices and to provide direction needed to improve the outcomes for pregnant women in Missouri.

Measure	Before MO HEALTHNET	2003	2004	2005	2006	Jan to Sept 2007
Mental Health						
Average Behavioral Health LOS	NA	9.1D	6.7D	6.4D	6.6D	7.0D
Asthma						
Asthma Admissions <18 Y/O per 1000	8.7%	5.3%	5.2%	5.0%	4.6%	4.9%
Asthma Admissions 4-17Y/O per 1000	6.7%	4.3%	4.4%	4.2%	4.0%	4.0%
Asthma ER Visits 4-17 Y/O per 1000	32.2%	27.6%	23.7%	21.1%	23.3%	24.6%
Asthma Admissions Ages 18-64 per 1000	NA	2.3%	2.2%	2.2%	2.4%	2.4%
Emergency Room						
ER visits <18 Y/O per 1000	748.5	597.1	673.5	594.7	648.8	692.7
ER visits ages 18-64 YO per 1000	NA	1009.7	966.0	938.3	1070.4	1168.6
Hysterectomies per 1000	NA	7.7%	7.9%	6.5%	6.3%	5.4%
Vaginal Hysterectomies	NA	16.1%	28.0%	27.6%	24.3%	24.0%
Preventable hospitalizations	22.6%	13.0%	12.6%	12.4%	12.6%	13.5%
< Age 20						

Analysis of the Trends in Medicaid Baseline vs. Last 57 Months MO HealthNet reveals some opportunities for improvement. Harmony support initiatives at the state level and within the plan to attempt to improve the trends reported. Harmony Behavioral Health trends utilization and trending reporting to the QIC committee. The number of inpatient days has been lower than the average reported in this report. On that note Harmony Health plans membership remains small

and predominately pregnant women and children. Harmony health Plan encourages providers to perform peri-natal and post partum depression screening to identify members in need of mental health services.

Even though HEDIS data was not reported on asthma due to low numbers of members who qualify for this measure Harmony Health Plan recognizes the burden of asthma on members, providers, and medical cost. Research supports people with asthma that are connected to a medical home and follow regular treatment with appropriate medications per the clinical guidelines for asthma have much better control of their symptoms, decreased Emergency Room visits, and admissions.

Harmony Health Plan provides disease and case management on identified members with persistent asthma. Members of the Health Services department participate in community coalitions to support community initiatives to decrease the burden of asthma, increase patients knowledge of asthma, and provider knowledge of appropriate medications, and educate the public on asthma. Through an ER Outreach Program Harmony Health Plan reaches out to members that have frequent Emergency Room visits. Asthma is a frequent diagnosis for treatment in the Emergency Room.

A description of the ER program follows:
Harmony Health Plan of MO ER Outreach Program - Quick Guide 2007
Level 1 (1-3 visits/Qtr) – ER Brochures

1. Outreach Coordinator (OC) maintains reviews and actively works monthly facility system generated ER reports.
2. OC identifies Level 1 range members. Begin working report within 24 hours of receipt.
3. OC verifies member eligibility.
4. OC mails ER brochures to members (above).
5. OC maintains (internal) Database productivity report regarding members identified, contacted and mailings sent.
6. OC monitors data for additional member ER visits.

Level 2 (4-6 visits/Qtr)
1. Outreach Coordinator (OC) maintains reviews and actively works daily and monthly facility and system generated ER reports.
2. OC identifies members on the report within Level 2 and begins working report within 24 hours of receipt.
3. OC verifies eligibility and then telephonic outreach and documents within the internal database.
4. OC generates appropriate ER outreach letter, Urgent Care Listing and magnet (proposed) to member within 5 days.
5. OC sends mass fax, email and/or outreach letter to PCP's for notification and provision of listing of members accessing ER within 5 days of opening case.

Level 3 (7+ visits/Qtr)

1. Outreach Coordinator (OC) maintains reviews and actively works daily and monthly facility and system generated ER reports.
2. OC identifies members on the report within Level 3 and begins working report within 24 hours of receipt.
3. OC verifies eligibility and then refers case for Internal Case Management (ICM – pending Tampa support).
4. Outreach Coordinator places 2 consecutive telephonic contact attempts with the member within 2 days of opening case
5. OC generates appropriate ER outreach letter, Urgent Care Listing and magnet (proposed) to member within 5 days.
6. The OC places outreach call to PCP in conjunction with the mailing of the Outreach letter being sent to member.
7. PCP is informed of frequent ER utilization and a care/treatment plan is discussed.
8. Refer to case/disease management for additional follow up and utilization of additional resources as appropriate.
9. High ER Volume utilization may be addressed with the PCP by medical and/or senior Health Plan Staff.

To assist in decreasing preventable hospitalizations Harmony Health Plan regularly reviews inpatient admissions. Utilization Management reviews and report numbers of admissions and trends to the QIC. The health service team reinforces provider education encouraging observation days for members that are not clearly meeting inpatient criteria but may warrant further evaluation.

HealthCare USA

Performance Measures
HealthCare USA continues to calculate the MO HealthNet Managed Care Performance Measures as required by the State contract. Other structure, process and outcome measures to assess timeliness, safety, efficiency, effectiveness, and satisfaction with HealthCare USA programs and services are also collected, analyzed and reported to different committees, performance improvement teams, task forces, the QMC, the Executive Quality Committee, and the Board of Managers..

HEDIS measures are calculated and reported in accordance with NCQA technical specifications. Reported measures are calculated using NCQA certified software and results are audited by an NCQA certified auditor. HEDIS rates continue to be reported for Central, Eastern, and Western regions of Missouri. CAHPS child surveys are completed by an independent vendor, DSS Research, that also completes the analysis and generates our reports annually. EPSDT ratios are collected and reported to the plan by the state.

HEDIS rates and EPSDT ratios are used as a means of evaluating the effectiveness of quality improvement interventions and to identify and prioritize additional opportunities for on-going improvement of the health of members. HealthCare USA's goal is to meet and exceed the

National Medicaid HEDIS 75th percentiles. Many improvement processes have been implemented to improve EPSDT ratios and HEDIS rates over the past two years.

HealthCare USA utilizes an interdepartmental, multi-disciplinary committee that meets monthly to review EPSDT, HEDIS and CAHPS measures. The committee reviews results analyzed by quality improvement staff and brainstorms ideas to improve each indicator, including revising interventions for member and provider education, assessing for and eliminating real and perceived barriers, identifying member incentives and provider resources, and assessing and resolving barriers in data collection and reporting processes.

EPSDT, HEDIS and CAHPS results and initiatives are reported to the Quality Management Committee, Executive Quality Committee, and Board of Managers. Feedback from these committees, including network providers, is requested.

HealthCare USA recognizes the unique membership and various geographic challenges across the state from the most urban to most rural areas. For this reason, overall results and result from the eastern, central and western regions are analyzed and reviewed for challenges particular to each region. Interventions can then be targeted to address both statewide barriers and issues unique to various geographic areas within the state.

HEDIS

Childhood Immunizations

Medical record reviews continue annually in order to obtain the most accurate reflection of our membership's immunization status. HealthCare USA continues to provide birthday and follow up mailed reminders for well care visits, immunizations and dental check ups for children and adolescents. The importance of well care check ups and screenings, immunizations and dental care, and the recommendations and guidelines provided by the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) and the American Academy of Family Practice (AFP) are included in member and provider newsletters, the member handbook, provider resource guide and online through HealthCare USA's provider site and the member's site.

- Central: Childhood immunizations both combination 2 and 3 improved from the 2007 plan result and are above the Medicaid mean.
- Eastern: Combination 2 remained exactly the same from the 2007 plan rate and still below the Medicaid mean. Combination 3 improved from the 2007 plan rate but remained below the Medicaid mean.
- Western: Combination 2 fell slightly from the 2007 plan rate and is below the Medicaid mean. Combination 3 increased from the plan rate but remains below the Medicaid mean.
- Summary: All three regions saw an increase in the combination 3 rate. The combination 3 includes a series of four vaccines. During HEDIS 2007, many immunization records only had 3 out of the 4 in the series completed, due to a shortage of the . The increase in the rates from HEDIS 2007 to HEDIS 2008 may be a reflection of the pneumococcal vaccine being fully available. Central continues to have higher overall immunization rates.

<u>Cervical Cancer Screening</u>
HealthCare USA uses Coventry's member reminder system to assist in educating eligible members regarding cervical cancer screening and Pap smears via a brochure, called ―Staying Healthy: A Guide For Women" mailed to female member members ages 21 to 64 years of age who meet HEDIS technical specifications for cervical cancer screening but do not have a claim for a cervical cancer screening. This mailing began in 2006 and continues bi-annually. Members are also educated at least once per year in the member newsletter, which is sent to all members. For HEDIS 2008, medical record review was completed in the Western region. This was in response to a lower rate in the Western region HEDIS 2007 rates. In addition, the acquisition in the spring of 2007 of the Firstguard membership resulted in an increase of new members in the western region. Since the measure allows Pap smears in the measurement year and the year prior, it was believed that claim results alone would be missing a large number of numerator-compliant women because of the lack of claims information from the previous year. The medical record review did increase the rate from 38.99% to 55.22%. Mid-year in 2007 a HEDIS test-run identified those in the Western region who did not have a claim. These members received an additional well woman flyer.

- Central: Cervical cancer screening rates declined from 2007, but remains above the Medicaid mean.
- Eastern: The rate decreased a statistically significant amount from the 2007 result, but remained above the 2007 Medicaid mean.
- Western: The rate increased from the 2007 rate, and remains below the Medicaid mean.
- Summary: Central and Eastern rates both decreased from 2007 to 2008. Medical record review was completed for this measure in the Western region only. The administrative rate fell below the 2007 plan result as well. In 2008, HealthCare USA identified a large number of claims that were billed using a non-NCQA code in 2007 and 2008. HealthCare USA is working with the NCQA auditor to capture these claims for numerator compliance for HEDIS 2009.

<u>Chlamydia Screening</u>
HealthCare USA began a performance improvement project in 2006 to increase member and provider knowledge and understanding related to Chlamydia and the need and evidence-based guidelines for Chlamydia screening. An educational flyer, ―Staying Healthy: A Guide to Women" is sent to all eligible members once per year as prompted through Coventry's member reminder system that identifies eligible members who do not have a claim for Chlamydia screening. Member and provider education is also included in the member handbook, the provider resource guide, in member and provider newsletters and accessible on-line to both members and providers.

- Central: The 2008 rate decreased as compared to the 2007 plan result but remains above the 2007 Medicaid mean.
- Eastern: The 2008 rate fell below the 2007 rate as well, but remains well above the 2007 Medicaid mean.
- Western: Result was stagnant and remains above the Medicaid mean.
- Summary: Review of the results in all three regions resulted in completion of a drilldown analysis. The decrease was also discussed with the national HEDIS team. It was found that

across the country all HEDIS rates for Chlamydia screening had decreased. Additional review of the process for claims filing for Chlamydia screens identified over 4000 claims submitted by the state lab using a code that is not adherent to NCQA technical specifications. A task force including representatives from other MO Managed Care plans, MO HealthNet representatives and other state representatives was formed to address and resolve the claim coding barrier to HEDIS data collection and reporting. Based on 2008 rates, elimination of this barrier may increase HealthCare USA Chlamydia screening rates 65% to 95%.

Mental Health Follow Up Within 7 and 30 Days
In 2007, MHNet embarked on an ambitious performance improvement project to increase the HEDIS rates for mental health follow up. This project included improved discharge planning from mental health facilities and improved coordination of care and contact with members recently discharged. Interventions included establishing an option for home visits follow up in addition to provider office visits.

- Central: Follow up within 7 days and 30 days both significantly increased from the 2007 plan result and are above the Medicaid average.
- Eastern: There was a significant increase in the 30 day follow-up from the 2007 plan result and this result at the Medicaid average. The 7 days follow-up rate also increased but remains below the Medicaid average.
- Western: Both measures increased from the 2007 rate. Follow Up in 30 days is slightly below the Medicaid mean and follow up in 7 days is below the Medicaid mean.
- Summary: Rates in all three regions increased for both measures, attributed to MHNet's performance improvement project.

Use of Appropriate Medications for People with Asthma
HealthCare USA began in the fall of 2007 a member incentive program entitled ―Asthma Around the World." This program is designed to entice members to see their PCP, their school nurse or other support person, and their pharmacy. The feedback has been very positive as indicated by results measured. In addition, the Asthma Disease Management program reviews pharmacy claims data each month to identify members enrolled in the asthma disease management program who do not have a claim for refilling controller and rescue medications. Outbound calls are made to those members who do not have pharmacy claims indicating a refill to remind them about the member incentive and the importance of refilling and using asthma medications as prescribed, and to identify and resolve any issues or barriers to getting prescribed medications.

- Central: Combined ages rate increased from the 2007 plan result and is now above the Medicaid mean.
- Eastern: Rate is slightly above 2007 plan result and slightly below Medicaid mean.
- Western: Rate is above 2007 plan result and is now above the Medicaid mean.
- Summary: the rate for use of appropriate medications for people with asthma increased across all three regions to or above the Medicaid mean.

Annual Dental Visit
HealthCare USA has been proactive in providing dental care to our members. During back to school fairs and at dental fairs, dental assessments are conducted by a hygienist. Any members

identified as needing additional interventional services of a dentist are called by Customer Service Representatives shortly after the fair and assisted in locating a dentist. Transportation is also arranged when necessary. A case manager may also contact a member identified in need of dental services to assist in arranging dental care, transportation, etc.

- Central: Rate improved a statistically significant amount from the 2007 result but remains below the Medicaid average.
- Eastern: Rate is above the 2007 result but remains below the Medicaid average.
- Western: Rate is above the 2007 result but remains below the Medicaid average.
- Summary: Rates improved in all three regions, but especially in the Central region. Central region's increase may be at least partially attributable to an increase in the number of providers leading to an increase in member access, and an increased awareness and access to screening provided at health fairs and dental fairs.

Well Child Visits Overall
HealthCare USA continues to send proactive reminders to members about EPSDT visits, and sending retrospective reminders for those not numerator compliant. HealthCare USA is an integral partner and leader of the State-wide initiative to improve adolescent well care.

Well Child Visits Ages 3-6
- Central: Rate increased from 2007 result but remained below the Medicaid mean.
- Eastern: Rate increased from the 2007 result but remained below the Medicaid mean.
- Western: Rate increased a statistically significant amount from the 2007 plan result but is still below the Medicaid average.
- Summary: All three regions improved, but remain below the Medicaid average. Medical record review was performed for this measure in Western region. However, the statistically significant improvement in rates was from the administrative rate (49.79 to 53.27).

Adolescent Well Child Visits
- Central: Rate improved from 2007, but remains below the Medicaid average.
- Eastern: Rate improved from the 2007, but remains below the Medicaid average.
- Western: Rate increased from the 2007, but remains below the Medicaid average.
- Summary: While the rate improved in all three regions, a significant opportunity for additional improvement remains.

Well Child Visits First 15 Months of Life – 6 or More
- Central: Rate declined slightly from 2007, but remains well above the Medicaid average.
- Eastern: Rate declined slightly from 2007, and remains below the Medicaid average.
- Western: Rate improved from 2007, and remains below the Medicaid average.
- Summary: This measure shows wide variation between the regions. Central region historically has a higher well child visit rate and higher immunization rates as compared to the other two regions. When looking at other indicators outside of HEDIS, consistently there are more visits to PCPs. Perhaps this is a result of less member movement in the central region and an associated increase in the likelihood of the member having a medical home. Having a

medical home has been identified as a factor in increasing routine healthcare and maintenance.

Prenatal and Postpartum
HealthCare USA continues to utilize an administrative database and methodology to acquire dates of prenatal visits from internal referral data. Medical record review continues for HEDIS 2008 to garner the most accurate reflection of our rates. A maternity incentive plan, the Beary Important Bundle prenatal visit incentive program, was piloted in the Eastern region in 2007 and was enthusiastically embraced by providers and members. This program encourages women to schedule and keep their prenatal and postpartum appointments.

Another intervention is a focus study in the Central and Western regions that provide a payment to any provider who submits a claim with a modifier for a postpartum visit that is included in a global payment. The belief is providers are not submitting claims for postpartum visits because the postpartum visit is part of the global authorization payment process. Reimbursing the provider for submitting the postpartum visit claim enables HealthCare USA to access the data and ―thanks" the provider for their effort. Again this program was well-received, and resulted in an increased administrative postpartum rate.

Timeliness of Prenatal Care
- Central: Rate declined slightly from 2007 but remains above the Medicaid mean.
- Eastern: Rate increased from the 2007 result and is now above the Medicaid mean.
- Western: Rate decreased from 2007 result but is still above the Medicaid mean.
- Summary: All three regions rates remain well above the Medicaid mean.

Postpartum Visit
- Central: Rate increased from 2007 result and is above the Medicaid mean.
- Eastern: Rate improved from 2007 result but remains below the Medicaid mean.
- Western: Rate declined from 2007 result but remains above the Medicaid mean.
- Summary: The Eastern region is the only rate below Medicaid mean, and issues unique to a high volume provider in this region plus an issue applicable to all regions that negatively impact post partum rates have been identified. A large FQHC servicing the Eastern prenatal/postpartum population has been identified as encouraging their patients to complete the postpartum visit at their newborn's one week pediatric visit as a way to complete both exams in one trip. While the plan appreciates the clinic's efforts to obtain care for their patients (and our members), the postpartum visit is not numerator-compliant when completed at one week post partum. The clinic believes the system is working well for them and is resistant to change. Another issue is the high-risk pregnant members referred to a Maternal Fetal Medicine specialist (MFM) for high risk care, and then referred back to the OB for postpartum care. Likelihood exists that the member does not return to the OB for follow-up. Further investigation and analysis to improve coordination of care in this area is needed.

Emergency Department Visits
HealthCare USA continues a performance improvement project to reduce Emergency Department (ED) utilization for non-emergent and avoidable reasons. This PIP initially identified those with 3 or more visits to the ED with a non-emergent or avoidable diagnosis code

in a 6 month time period. These members are referred for case management or disease management needs assessments. An educational flyer is mailed to each member. This flyer has information on first aid topics such as how to treat minor cuts and scrapes to how to take a temperature. Each first aid topic also includes suggestions on when to consult a PCP or seek immediate care. This mailing was altered to now include information about what a PCP is, why having a medical home is important and how to access the right care at the right place, be it routine, urgent or emergent.

ED utilization by members enrolled in the asthma disease management program is measured and reported routinely to the PIP team, the asthma task force, the Physician Advisory Council and QMC. ED utilization for members enrolled in the asthma disease management program decreased 17% from the 2006 baseline and an additional 12.5% in the first two quarters of 2008. This reduction is most likely related to an increase in adherence to asthma medications and primary care visits, an increase in the number of members who have an asthma action plan and improved early recognition and action by members/caregivers for signs of an asthma exacerbation.

This PIP team was revised to be an interdepartmental team that meets to review ED data, discuss ideas and develop interventions related to ED use. Since ED usage is multi-faceted, and the committee has identified, analyzed, and researched many different aspects of ED over-utilization. The PIP and the committee work continued through 2008 and will continue during 2009.

In third quarter of 2008, a case management RN was hired to as a dedicated resource to make outbound calls to members who visited the emergency department. Calls include member education about appropriate use of the ED, who their PCP is and assistance to set up an appointment with the PCP, and identification and elimination of any barriers to completing follow up instructions provided by the ED.

- Central: Results declined from the 2007 rate but remain above the Medicaid mean.
- Eastern: Results increased from 2007 and remains above the Medicaid mean.
- Western: Result increased from 2007 and remains above the Medicaid mean.
- Summary: ED utilization rates, while slightly decreasing among those going three or more times in six months and decreasing among members enrolled in the asthma disease management program, remain well above the Medicaid mean. The PIP team will continue to assess ED utilization data and implement interventions designed to reduce inappropriate and avoidable ED use.

Central Region

Central Region	National Medicaid Mean	HEDIS Results	
Measure	2007	2008	2007
Effectiveness of Care			
Childhood Imms Combo 2	73.4	77.08	71.30
Childhood Imms Combo 3	60.9	72.45	65.05
Cervical CA Screening	65.7	66.85	68.01
Chlamydia Screening	52.4	51.08	55.20
MH – Follow Up Within 30 Days	57.7	71.32↑	56.38
MH – Follow Up Within 7 Days	39.1	42.65↑	29.53
Access/Availability of Care			
Asthma Meds – Combo	87.1	87.36	85.67
Annual Dental Visit	42.5	35.08↑	32.73
WCV Ages 3-6	66.8	62.32	61.34
Adolescent WCV	43.6	40.19	39.06
WCV 1st 15 Mos of Life – 6 or More	55.6	71.36	72.65
Prenatal	81.2	91.40	92.08
Postpartum	59.1	72.79	69
Utilization			
MH Utilization-% Mbrs Receiving Services – Total	8.9	9.13	8.62
Identification of Alcohol & Other Drug Services: Total	2.2	0.72	0.77
Ambulatory Care			
Outpatient Visits/1000 Mbr Mos	316.8	362.83	354.89
ED Visits/1000 Mbr Mos	56.6	74.26	76.62
Surgery-Procedures/1000 Mbr Mos	5.3	4.99	5.03
Obs Room Stays Resulting in Discharge/1000 Mbr Mos	1.8	1.94	2.02

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.

Eastern Region

Eastern Region	National Medicaid Mean	HEDIS Results	
Measure	2007	2008	2007
Effectiveness of Care			
Childhood Imms Combo 2	73.4	64.12	64.12
Childhood Imms Combo 3	60.9	57.41	55.79
Cervical CA Screening	65.7	68.36↓	70.79
Chlamydia Screening	52.4	65.81	69.14
MH – Follow Up Within 30 Days	57.7	57.45↑	48.89
MH – Follow Up Within 7 Days	39.1	30.59	26.75
Access/Availability of Care			
Asthma Meds – Combo	87.1	86.87	86.43
Annual Dental Visit	42.5	34.61	32.52
WCV Ages 3-6	66.8	62.68	59.78
Adolescent WCV	43.6	40.35	36.49
WCV 1st 15 Mos of Life – 6 or More	55.6	42.90	43.76
Prenatal	81.2	83.53	79.26
Postpartum	59.1	54.76	52.78
Utilization			
MH Utilization-% Mbrs Receiving Services – Total	8.9	6.05	5.87
Identification of Alcohol & Other Drug Services: Total	2.2	0.68	0.58
Ambulatory Care			
Outpatient Visits/1000 Mbr Mos	316.8	229.70	223.03
ED Visits/1000 Mbr Mos	56.6	72.68	69.57
Surgery-Procedures/1000 Mbr Mos	5.3	3.32	3.48
Obs Room Stays Resulting in Discharge/1000 Mbr Mos	1.8	1.42	2.52

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.

Western Region

Western Region	National Medicaid Mean	HEDIS Results	
Measure	2007	2008	2007
Effectiveness of Care			
Childhood Imms Combo 2	73.4	65.05	66.44
Childhood Imms Combo 3	60.9	55.56	53.94
Cervical CA Screening	65.7	55.22	53.74
Chlamydia Screening	52.4	59.10	59.22
MH – Follow Up Within 30 Days	57.7	57.51	53.85
MH – Follow Up Within 7 Days	39.1	35.53	28.21
Access/Availability of Care			
Asthma Meds – Combo	87.1	85.37	80.28
Annual Dental Visit	42.5	30.29	25.46
WCV Ages 3-6	66.8	60.42↑	49.79
Adolescent WCV	43.6	32.56	24.35
WCV 1st 15 Mos of Life – 6 or More	55.6	46.07	43.72
Prenatal	81.2	86.11	90.74
Postpartum	59.1	61.34	65.05
Utilization			
MH Utilization-% Mbrs Receiving Services – Total	8.9	1.04	3.26
Identification of Alcohol & Other Drug Services: Total	2.2	6.43	0.62
Ambulatory Care			
Outpatient Visits/1000 Mbr Mos	316.8	310.10	290.40
ED Visits/1000 Mbr Mos	56.6	88.36	86.17
Surgery-Procedures/1000 Mbr Mos	5.3	3.20	3.76
Obs Room Stays Resulting in Discharge/1000 Mbr Mos	1.8	1.47	2.37
↑ or ↓ indicates a statistically significant change from the previous year's plan rate.			

Childhood CAHPS

HealthCare USA utilizes the NCQA developed CAHPS Child Survey to measure the satisfaction of the membership in each of the three regions across Missouri. DSS Research conducted this survey for HealthCare USA and has done so for the past several years, making comparisons between the years reliable. DSS Research also makes available a comparison between the

current year results and the previous year's Medicaid average. An analysis and final report is developed by DSS Research upon completion of the survey.

The survey is mailed to parents of those members 17 years and younger who have been continuously enrolled in the plan for at least five of the last six months of the measurement year. HEDIS technical specifications for survey measures were followed for the data collection. A possible total of two mailers, each followed by a reminder postcard, were sent to each member. Fifty-six days after the second reminder postcard was mailed and no response was received, telephone interviewing was initiated. A total of 81 days was allowed to collect all completed surveys.

Overall, HealthCare USA was very pleased with the results. Improvement was shown in most indicators. An interdepartmental, multi-disciplinary workgroup reviewed all of the results to identify barriers and brain storm possible interventions for improvements.

Sampling
Eastern region:
In 2008, a sample of 470 members was obtained in which the overall sampling error $\pm4.5\%$ at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 29.07%.

Central region:
In 2008, a sample of 570 members was obtained in which the overall sampling error is $\pm 4.1\%$ at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 35.29%.

Western region:
In 2008, a sample of 423 members was obtained in which the overall sampling error is $\pm 4.8\%$ at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 26.42%.

Health Plan Overall Eastern Region

80.1%	85.5%	81.5%	83.5%	79.5%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average

Health Plan Overall - Central Region

80.1%	79.3%	80.6%	83.6%	79.5%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average

Health Plan Overall Western Region

80.1%	76.6%	78.5%	78.9%	79.5%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average
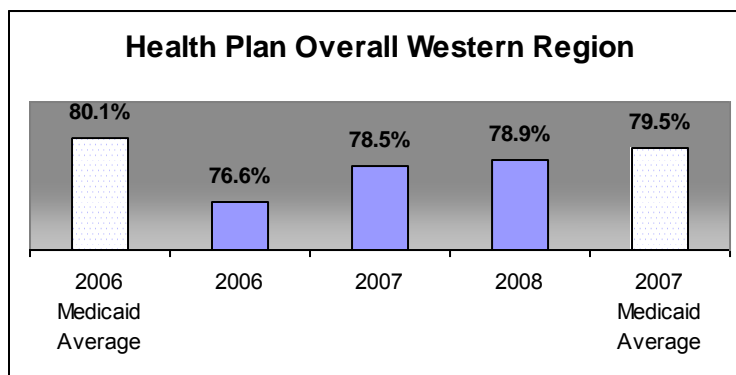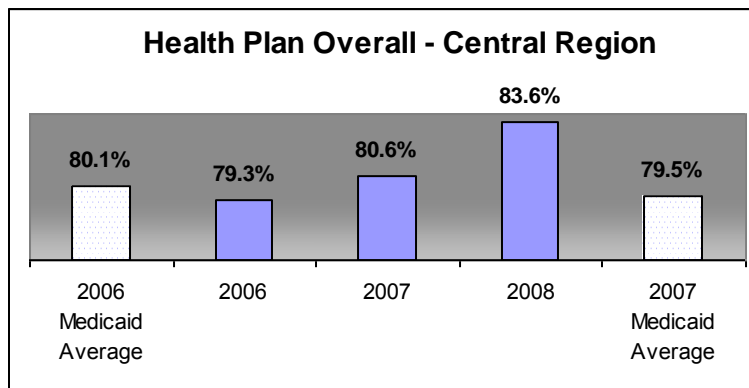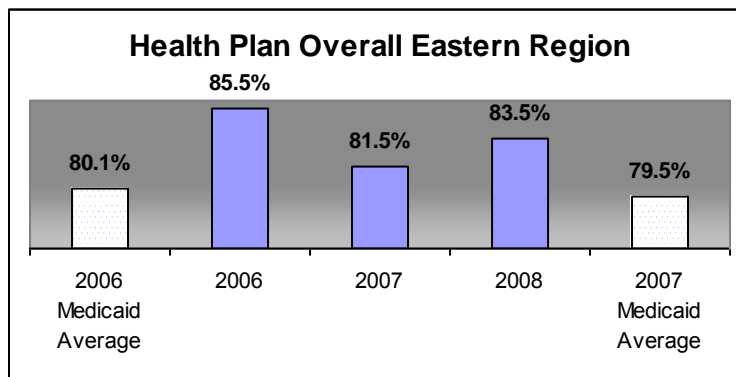
Results for Health Plan Overall-Discussion

Eastern Region:
- The Health Plan Overall results for 2008 were higher than 2007, and significantly higher than the 2007 Medicaid average.
- Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control.
- For 2008, the customer service composite score average increased from 2007 and is significantly above the 2007 Medicaid average.
- In 2008, the percentage of reported complaints or problems decreased from last year and is below the 2007 Medicaid average. For 2008, the reported percentage of complaint/problem resolution within 7 days increased from 2007 and is above the 2007 Medicaid average. The level of satisfaction for 2008 regarding complaint/problem resolution decreased from the previous year and is below the 2007 Medicaid average.
- Sample size <30 for complaints and resolution.

Central Region:
- The Health Plan Overall results for 2008 were higher than 2007, and significantly higher than the 2007 Medicaid average.
- Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control.
- For 2008, the customer service composite score average increased significantly from 2007 and is significantly above the 2007 Medicaid average.
- In 2008, the percentage of reported complaints or problems decreased from last year and is below the 2007 Medicaid average. For 2008, the reported percentage of complaint/problem resolution within 7 days increased from 2007 but is still below the 2007 Medicaid average. The level of satisfaction for 2008 regarding complaint/problem resolution increased from the previous year and is above the 2007 Medicaid average.
- Sample size <30 for complaints and resolution.

Western Region:
- The Health Plan Overall results for 2008 were slightly higher than 2007, but lower than the 2007 Medicaid average.
- Although all survey measures drive the overall health plan rating, customer service and complaints are directly under the health plan's control.
- For 2008, the customer service composite score average is higher than last year and is above the 2007 Medicaid average.
- In 2008, the percentage of reported complaints or problems decreased from last year but is still above the 2007 Medicaid average. For 2008, the reported percentage of complaint/problem resolution within 7 days increased from 2007 but is still below the 2007 Medicaid average. The level of satisfaction for 2008 regarding complaint/problem resolution increased from the previous year and is above the 2007 Medicaid average.
- Sample size <30 for complaints and resolution.

<u>Health Care Overall</u>

Health Care Overall Eastern Region

Year	Value
2006 Medicaid Average	82.4%
2006	85.6%
2007	79.5%
2008	81.9%
2007 Medicaid Average	81.0%

Health Care Overall Central Region

Year	Value
2006 Medicaid Average	82.4%
2006	82.8%
2007	83.7%
2008	83.2%
2007 Medicaid Average	81.0%

Health Care Overall Western Region

Year	Value
2006 Medicaid Average	82.4%
2006	73.7%
2007	72.0%
2008	83.0%
2007 Medicaid Average	81.0%

Health Care Overall-Discussion

Eastern Region:
- Health Care Overall result for 2008 is higher than the 2007 results and also higher than the 2007 Medicaid average.
- Getting needed care and getting care quickly are highly correlated to the overall health care rating.
- For 2008, getting needed care composite score increased from 2007 and is equal to the 2007 Medicaid average. The greatest opportunity for improvement is related to seeing a specialist.
- In 2008, the getting care quickly composite score decreased from last year, but is still above the 2007 Medicaid average. The greatest opportunity for improvement in this area is related to the measure for exam room within 15 minutes of appointment.

Central Region:
- Health Care Overall results for 2008 decreased slightly from 2007 but are still above the 2007 Medicaid average.
- Getting needed care and getting care quickly heavily influence overall health care ratings.
- For 2008, the getting needed care composite score decreased from 2007 and is slightly below the 2007 Medicaid average. The greatest opportunity for improvement revolves around seeing a specialist.
- In 2008, the getting care quickly composite score increased from last year and is significantly above the 2007 Medicaid average. The greatest opportunity for improvement in this area is related to the measure being taken to the exam room within 15 minutes of appointment.

Western Region:
- Health Care Overall results for 2008 increased significantly from 2007 and are above the 2007 Medicaid average.
- Getting needed care and getting care quickly heavily influence overall health care ratings.
- For 2008, the getting needed care composite score increased from 2007 and is below the 2007 Medicaid average. The greatest opportunity for improvement revolves around seeing a specialist.
- In 2008, the getting care quickly composite score increased from last year and is above the 2007 Medicaid average. The greatest opportunity for improvement in this region is also related to the measure being taken to the exam room within 15 minutes of appointment.

Personal Doctor Overall and Specialist Overall

Personal Doctor Overall Eastern Region

2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average
82.7%	83.5%	78.7%	84.2%	81.5%

Personal Doctor Overall Central Region

2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average
82.7%	80.8%	81.1%	83.3%	81.5%

Personal Doctor Overall Western Region

2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average
82.7%	75.7%	73.7%	77.6%	81.5%

Specialist Overall Eastern Region

79.2%	78.4%	70.7%	84.1%	77.8%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average

Specialist Overall Central Region

79.2%	77.4%	80.7%	75.2%	77.8%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average

Specialist Overall Western Region

79.2%	78.4%	70.7%	80.5%	77.8%
2006 Medicaid Average	2006	2007	2008	2007 Medicaid Average

Eastern Region:
- The Personal Doctor Overall rating for 2008 is significantly higher than 2007 and higher than the 2007 Medicaid average.
- The Specialist Overall rating for 2008 is significantly higher than the 2007 rating and higher than the 2007 Medicaid average.
- How well doctors communicate and courteous and helpful office staff heavily influence personal doctor and specialist ratings.
- For 2008, regarding how well doctors communicate, the composite score increased from 2007 and is slightly above the 2007 Medicaid average. The greatest opportunity for improvement in the composite score is related to the member's perception of doctors spending enough time with patients.
- For 2008, the courteous and helpful office staff composite score average increased from last year and is above the 2007 Medicaid average. The greatest opportunity for improvement in this area is related to the member's perception of doctors having helpful office staff.

Central Region:
- The Personal Doctor Overall rating for 2008 is higher than 2007 and higher than the 2007 Medicaid average.
- The Specialist Overall rating for 2008 is lower than the 2007 rating and lower than the 2007 Medicaid average.
- How well doctors communicate and courteous and helpful office staff heavily influence personal doctor and specialist ratings.
- For 2008, regarding how well doctors communicate, the composite score increased from 2007 and is significantly above the 2007 Medicaid average. The greatest opportunity for improvement in the composite revolves around doctors spending enough time with patients.
- For 2008, the courteous and helpful office staff composite score average decreased from last year but is significantly above the 2007 Medicaid average. The greatest opportunity for improvement in this measure is related to member's perception of doctors having helpful office staff.

Western Region:
- The Personal Doctor Overall rating for 2008 is higher than 2007 but below the 2007 Medicaid average.
- The Specialist Overall rating for 2008 is higher than the 2007 rating and higher than the 2007 Medicaid average.
- How well doctors communicate and courteous and helpful office staff heavily influence personal doctor and specialist ratings.
- For 2008, regarding how well doctors communicate, the composite score increased from 2007 and is significantly above the 2007 Medicaid average. The greatest opportunity for improvement in the composite score is related to member's perception of doctors spending enough time with patients.
- For 2008, the courteous and helpful office staff composite score average increased from last year and is significantly above the 2007 Medicaid average. The greatest opportunity for improvement is related to member's perception of doctors having helpful office staff.

<u>What HealthCare USA is Doing</u>

An interdepartmental committee meets annually after the CAHPS results are released. This committee reviews results analyzed by DSS and QI staff, then makes recommendations for identified areas of improvement. Each area of the CAHPS survey, by region, is discussed in detail. Actions taken in response to the 2008 survey include sharing results with providers to increase awareness of member perceptions and to identify actions providers can take, sharing results of the survey with members in the newsletter and gaining ideas and suggestions for specific actions from members at the Member Advisory Council meetings. Results of this survey are also reported to the QMC, the Executive Quality Committee and Board of Managers.

Trends in MO HealthNet Quality Indicators
This secondary-source report is received by HealthCare USA at the MO HealthNet Managed Care QA&I Advisory Group Meeting. HealthCare USA reviews this data and compares it to the HEDIS Indicators by Missouri MO HealthNet Managed Care Health Plans Within Regions, Live Births report, as well as internal data such as HEDIS rates.

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births (secondary-source reporting) are tracked according to MO HealthNet and are reported at the MO HealthNet QA&I Advisory Group Meeting. HealthCare USA analyzes this data to determine how we compare to other MO HealthNet Plans in the State, where we have improved and worsened, and how we can plan to improve the care of the MO HealthNet membership. All data for the graphs are from the MO HealthNet Managed Care ―Trends in MO HealthNet: Quality Indicators."
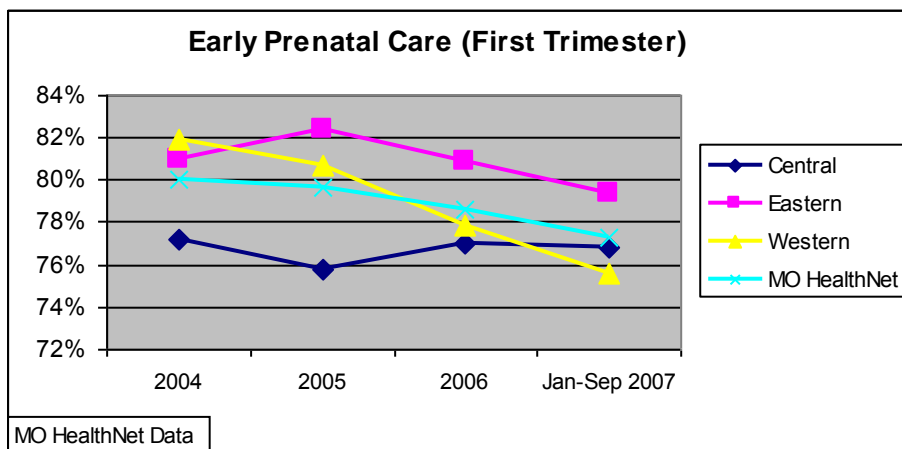
There was a downward trend in the rate of prenatal care obtained in the first trimester from 2005, resulting in a significant decrease in the rate from 2006 to 2007 in Eastern and Western regions. Central region remained relatively flat. This suggests potentially a barrier in access to care in the first trimester.

Prenatal Care Began in 2nd Trimester
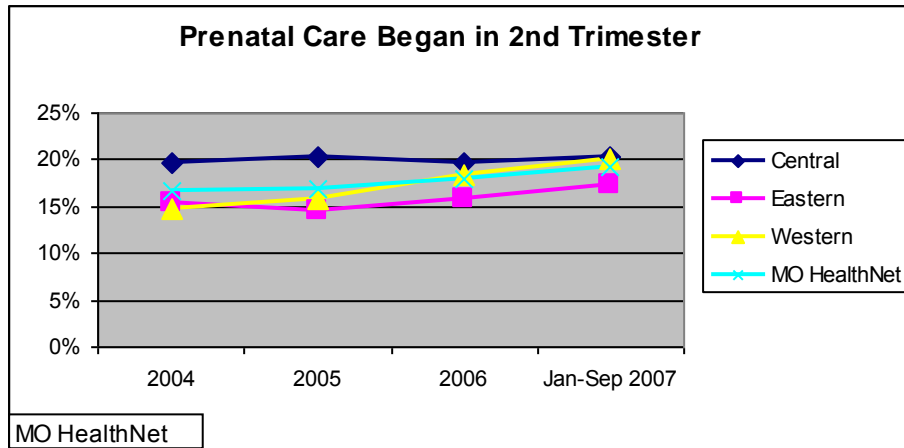
The rate of prenatal care beginning in the second trimester increased a significant amount in the Eastern and Western regions. The correlating drop for prenatal care in the first trimester in the same regions suggest pregnant members are not accessing prenatal care until the second semester at an increased rate. Potential reasons could be lag time from member positive pregnancy test and gaining access to prenatal care and/or lack of member knowledge regarding importance of prenatal healthcare beginning in the first trimester and/or providers not including the actual first date of a prenatal visit if it is prior to member enrollment in MO HealthNet and selection of a health plan.

Prenatal Care Began in 3rd Trimester
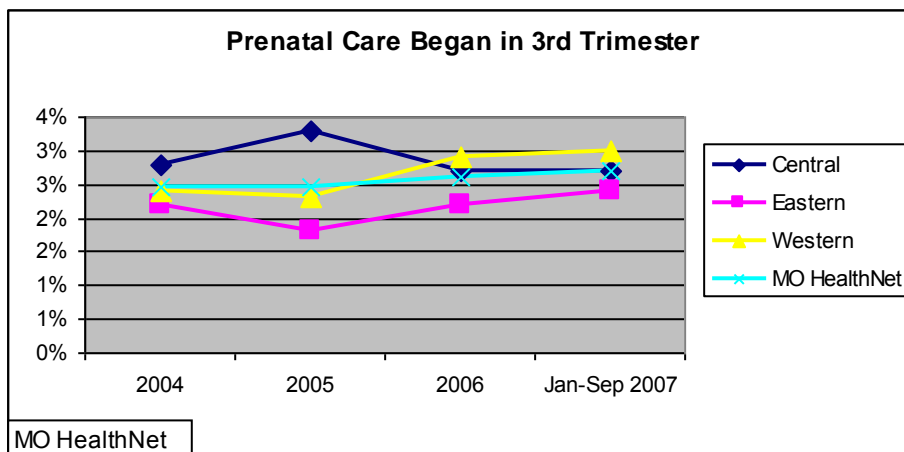
There has been a slight upward trend in Eastern and Western but not to a significant amount. Central region remains flat.

Trimester Prenatal Care Begun: None
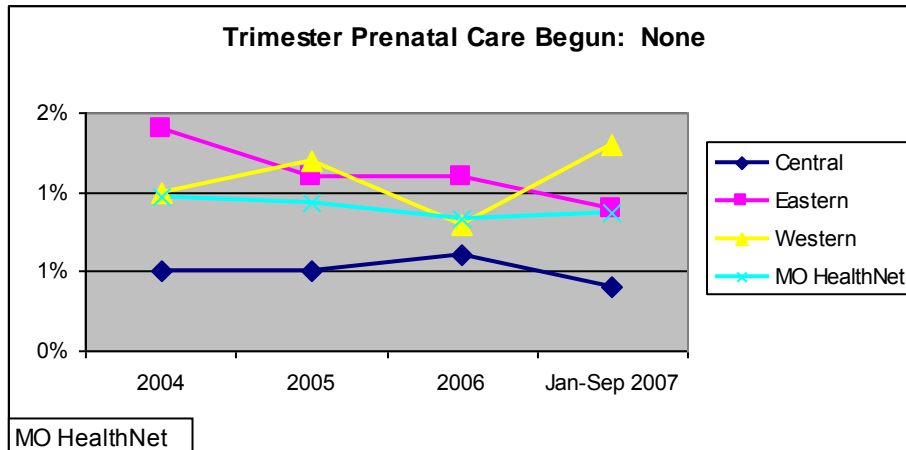
There was a significant increase in the rate of pregnant members with no prenatal care in the Western region in 2007 to date. Eastern and Central region rates decreased slightly. Possible causes could be a lack of prenatal claims due to member requested plan changes in the first quarter of 2007 or an increase in lag time between identification of pregnancy, completion of application and enrollment in MO HealthNet and selection and notification of new member enrollment to the health plan.

Trimester Prenatal Care Begun: Total
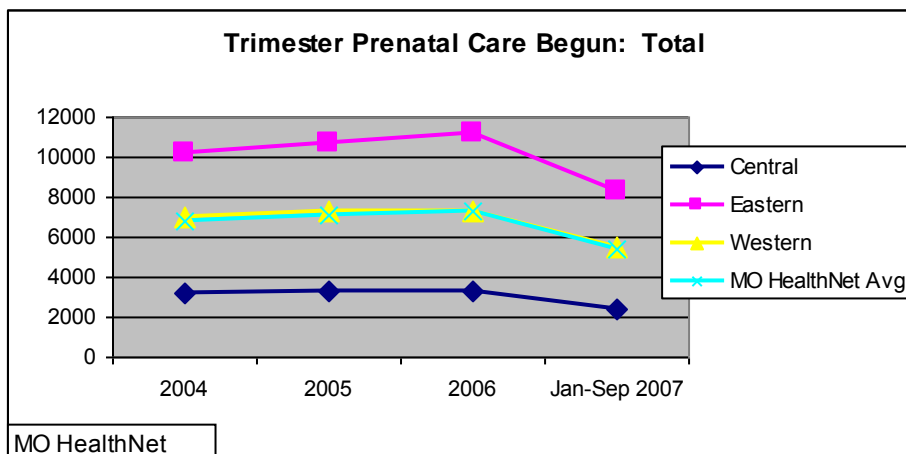
There was a decrease in total members receiving prenatal care in all three regions, potentially due to changes in MO HealthNet.

124

Inadequate Prenatal Care
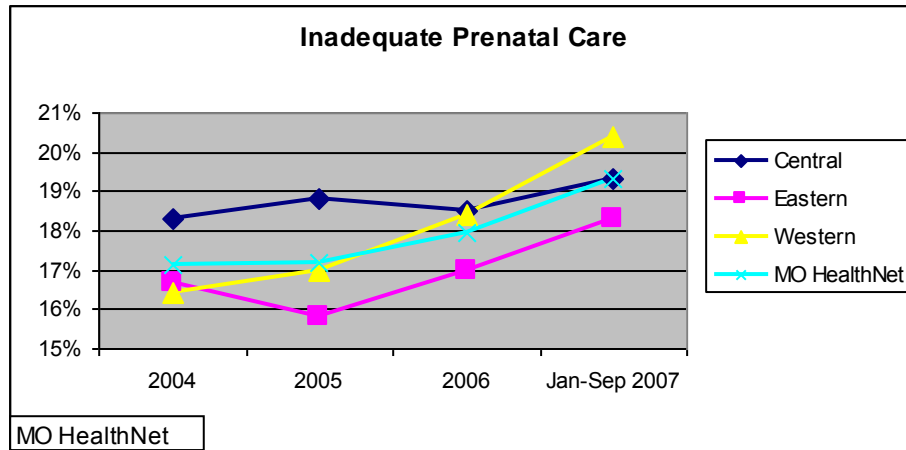
There was a significant increase in the rate of inadequate prenatal care in the Eastern and Western regions, with a slight increase in Central. This is consistent with a delay in start of prenatal care until 2nd trimester seen in the same regions.

Birth Weight <500 grams
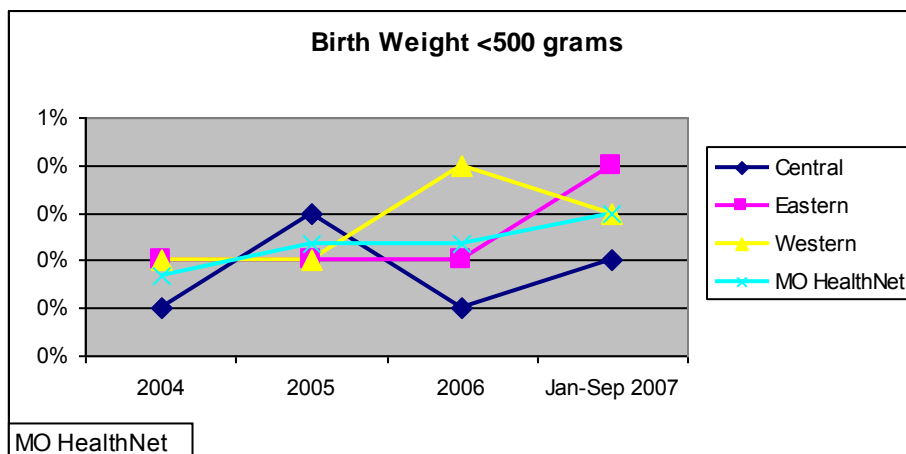
A significant increase in birth weights less than 500 grams occurred in the Eastern region. There was a slight decrease in Western region and a slight increase in Central region.
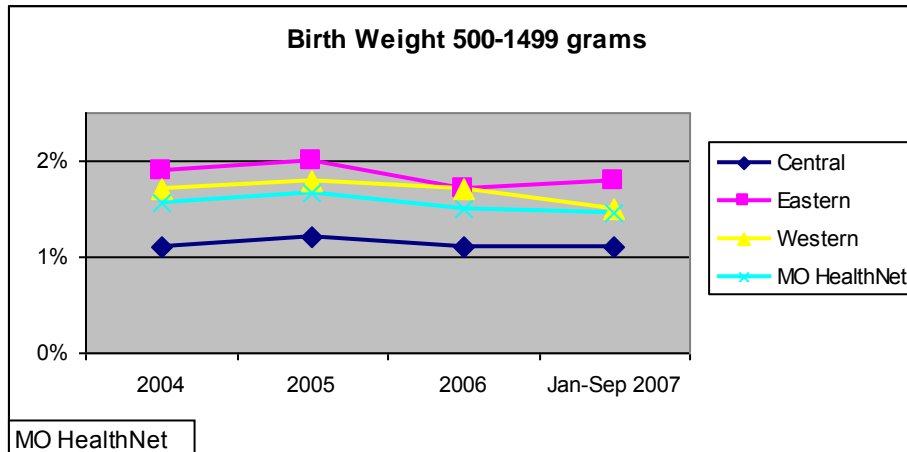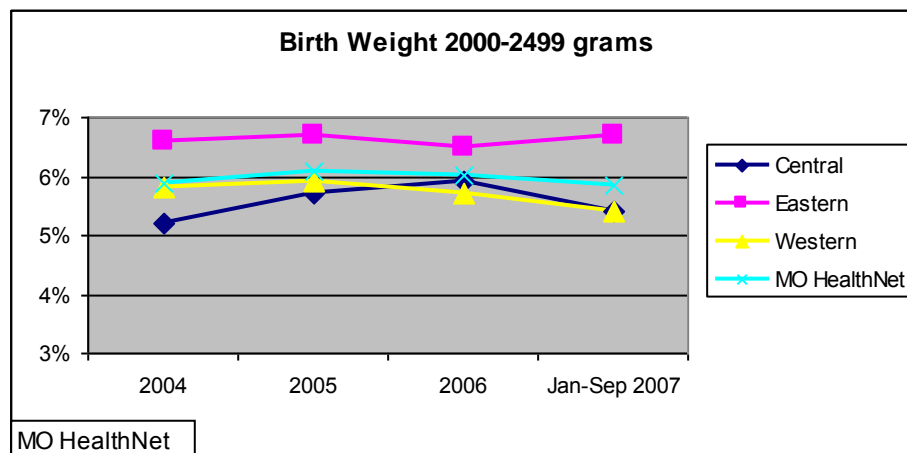
Birth Weight 500-1499 grams

There was no significant changes in any region from 2006 to 2007 to date.

Birth Weight 2000-2499 grams

There was no significant changes in any region from 2006 to 2007 to date.

Birth Weight 2500+ grams
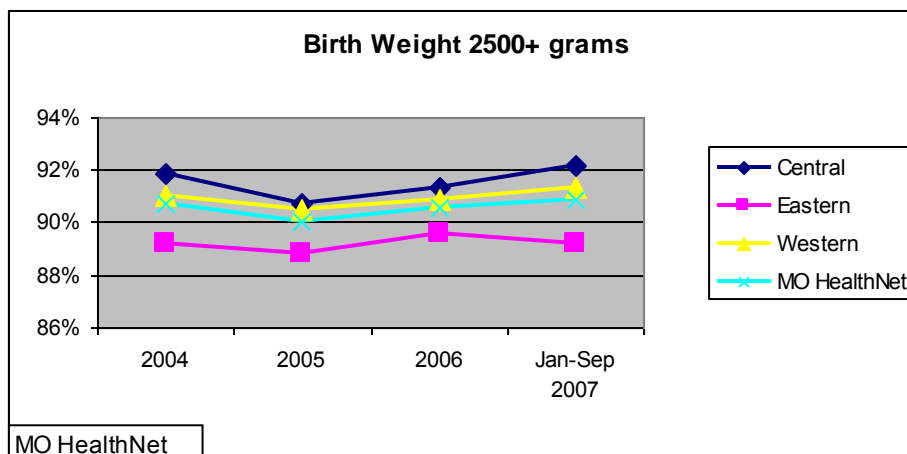
There was no significant changes in any region, even though Central and Western rates slightly increased, and Eastern region's rate declined slightly.
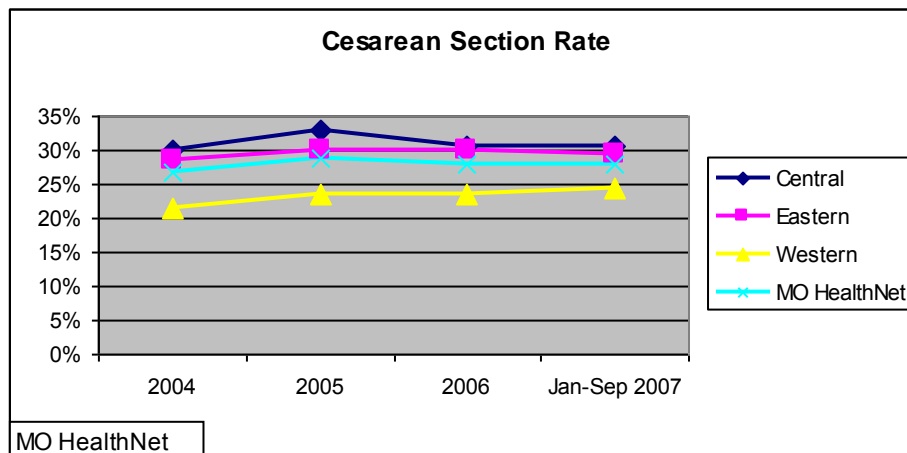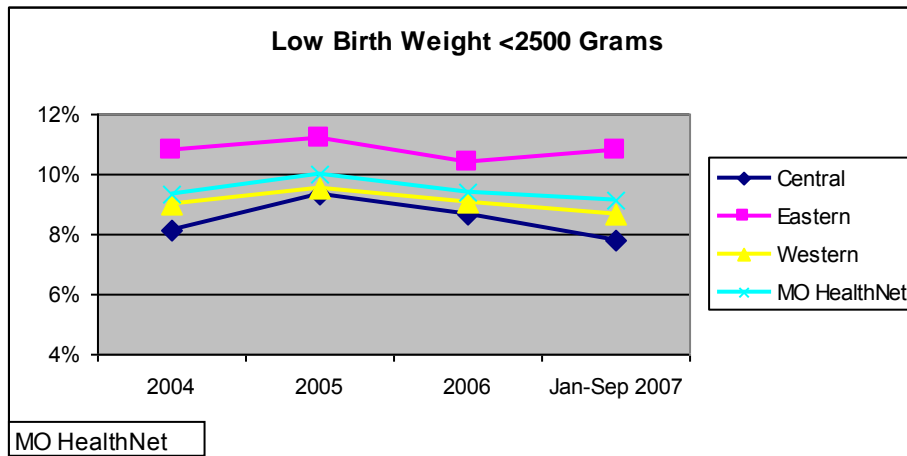
126

Low Birth Weight <2500 Grams

MO HealthNet

Cesarean Section Rate

MO HealthNet

There was no significant change in Cesarean Section rates for any region from 2006 to 2007 to date.

Vaginal Birth After Cesarean
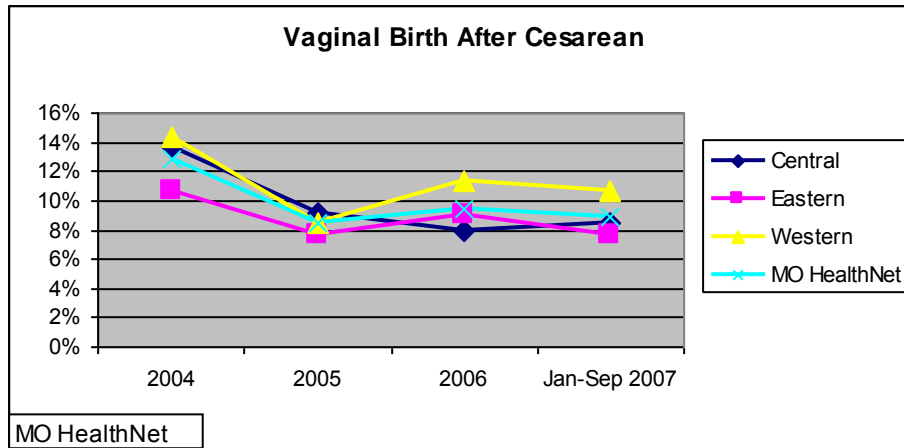
There was no significant change in the vaginal birth after Cesarean section rate for any region from 2006 to 2007 to date.

Repeat Cesarean Section
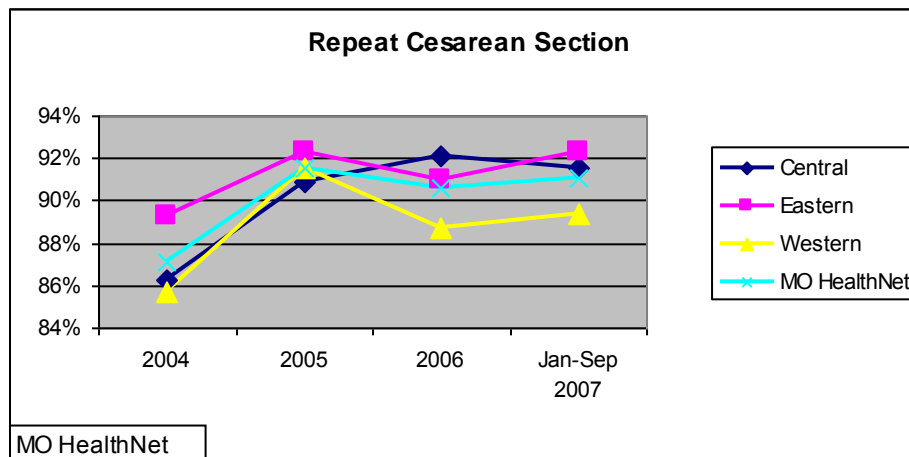
There was no significant change in the rate of repeat Cesarean sections in any region from 2006 to 2007 to date.

Smoking During Pregnancy

In the Eastern and Western regions a significant decline in the rate of smoking during pregnancy. There was no significant change in the Central region's rate, which remains higher than the rate in other regions and the MO HealthNet average.

Spacing of Births <18 Months
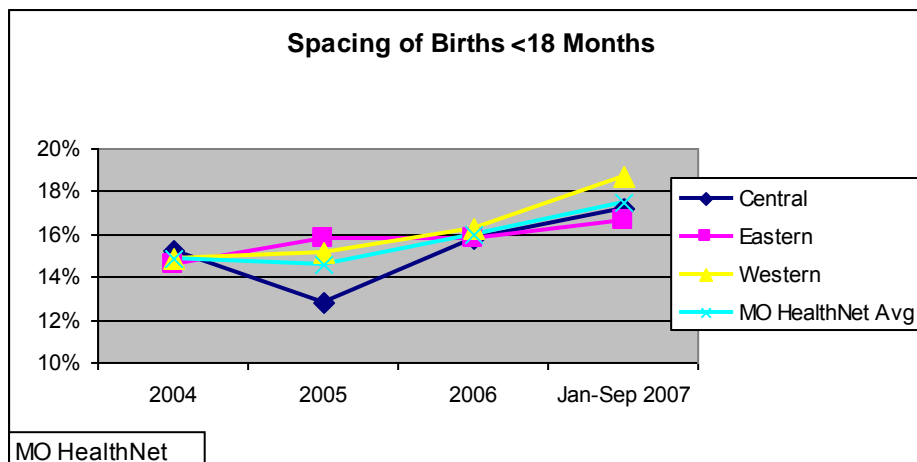
There was a significant increase in Central and Western regions' rates for deliveries less than 18 months after a prior delivery. The Eastern region's rate also increased, but not significantly. Potentially an increase in postpartum visits and family planning counseling could help reduce this rate. HealthCare USA utilized a postpartum member incentive to encourage attending a postpartum visit as prescribed by the members OB care provider. In addition, a provider payment to complete encounter data for post partum visits where payment is included in the global fee structure was piloted and then implemented state wide in June of 2008.

Births to Moms <18 Years Old
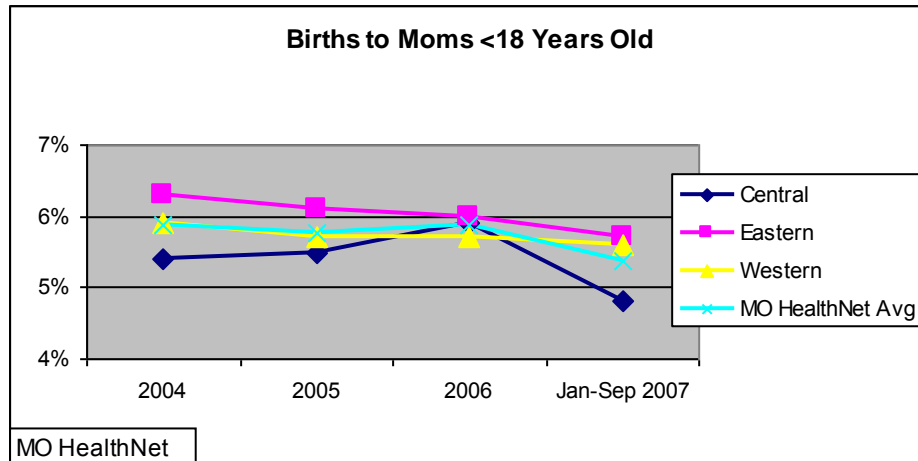
The rate of deliveries to moms less than 18 years of age decreased across all three regions. Even though not statistically significant at this time, it is a positive trend that started in late 2006 and has continued.
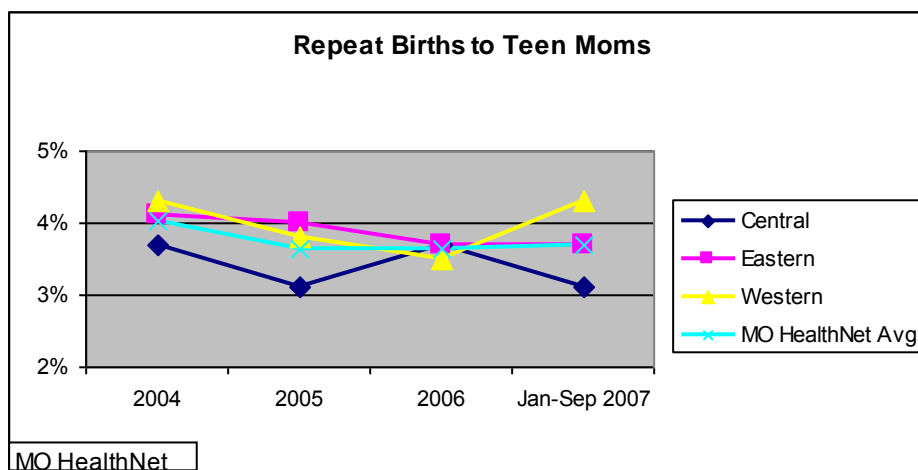
Repeat Births to Teen Moms

There was a decrease in the rate of repeat births to teen moms in Central and Eastern regions, but the Western region saw a significant increase in this rate.

Fetal Deaths (20+ Weeks Gest)/1000 Live Births

MO HealthNet
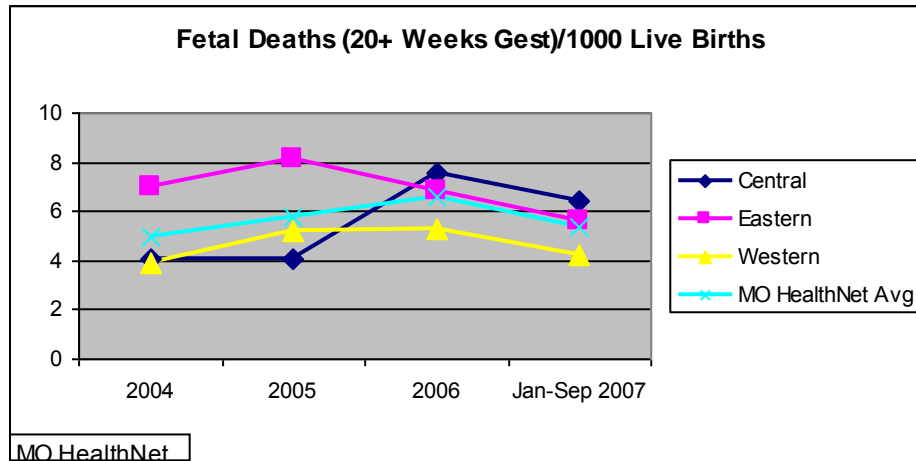
There was a decrease in the rate of fetal deaths per 1000 live births in all 3 regions, although not statistically significant. This could be reflective of either better prenatal care or better medical care to those babies born with life-threatening issues, such as prematurity or congenital defects.

Total Live Births or Stillbirth Fetuses (500+ grams) per 1000 Members

MO HealthNet
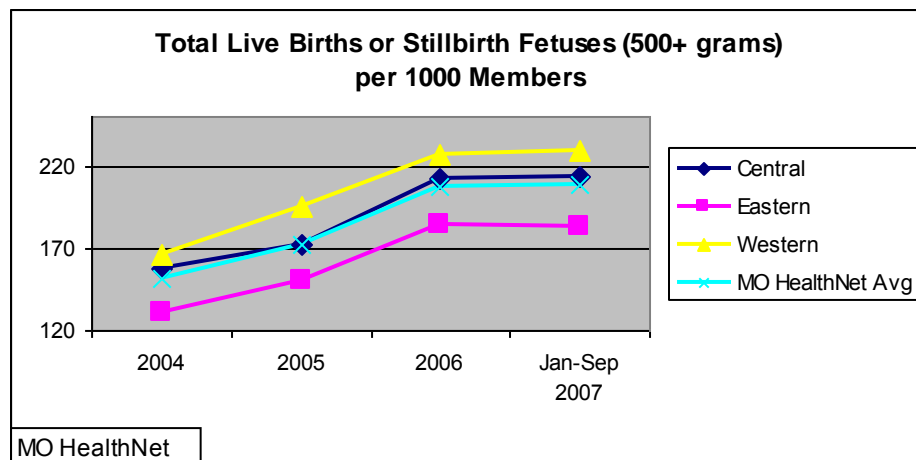
There was a significant increase in the rate of live births or stillbirth fetuses per 1000 in the Central region from 2006 to 2007 to date. Eastern and Western regions also had an increase in this rate. This may reflect stricter criteria for MO HealthNet eligibility, resulting in higher ratio of MO HealthNet members who only meet eligibility criteria as a result of a confirmed pregnancy.
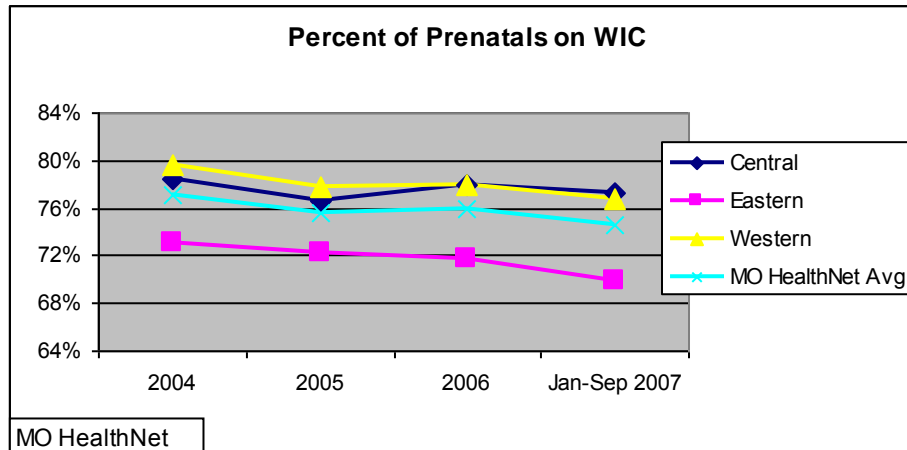
Percent of Prenatals on WIC

There was a significant decline in the rate of pregnant women on WIC in the Eastern and Central regions. Western region also declined, but not significantly.

Very Low Birth Weight <1500 Grams Not Delivered at Level III Hospital
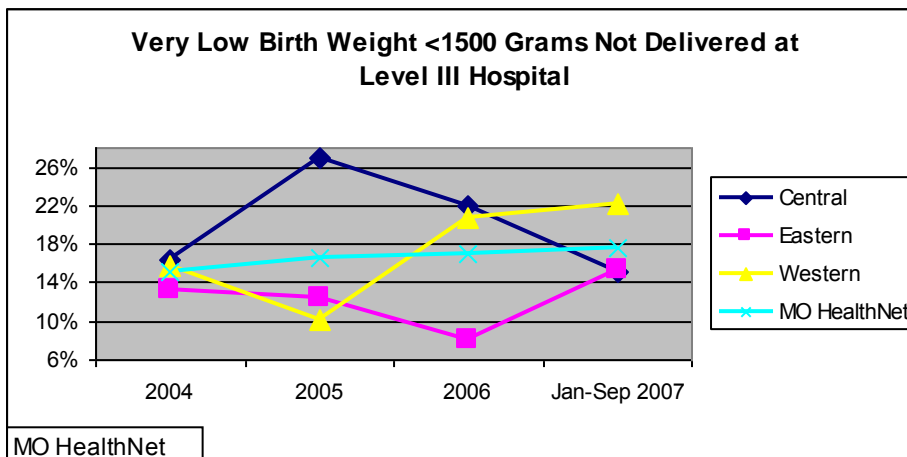
In the Eastern region there was a significant increase from 2006 to 2007 to date in the rate of VLBW babies not delivered at Level III hospitals, after a significant decline in this rate from 2005 to 2006. The other two regions had no significant change. Again, Eastern region continues to show significant negative trends overall for prenatal care and deliveries.

Average Maternal Length of Stay Inpatient Admits
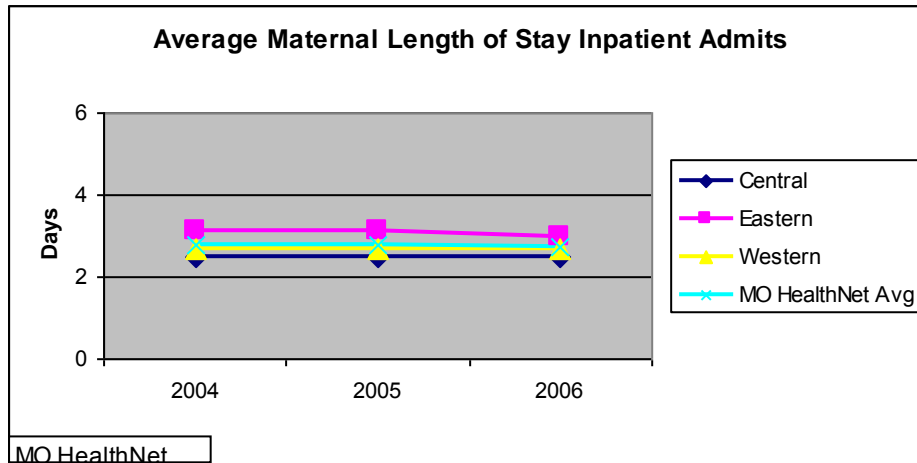
The average length of stay for maternal admissions remains consistent in all 3 regions.

Average Behavioral Health Length of Stay for Inpatient Admits
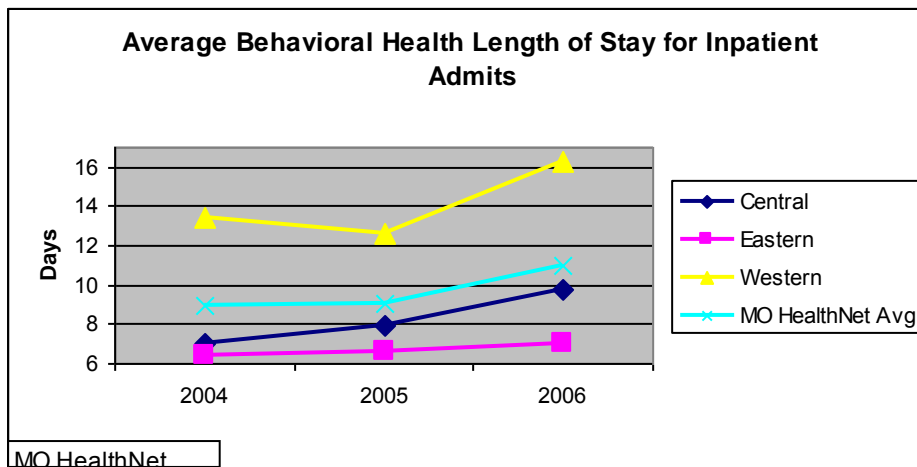
The average length of stay for behavioral health admissions has increased in Central and Western regions. Eastern region also had a slight increase. Western region's rate is significantly higher than the MO HealthNet average and the other plan rates. Potential reasons for the increase could be tighter MO HealthNet eligibility resulting in sicker people on MO HealthNet.

Asthma Admits Age 4-17 per 1000 Members
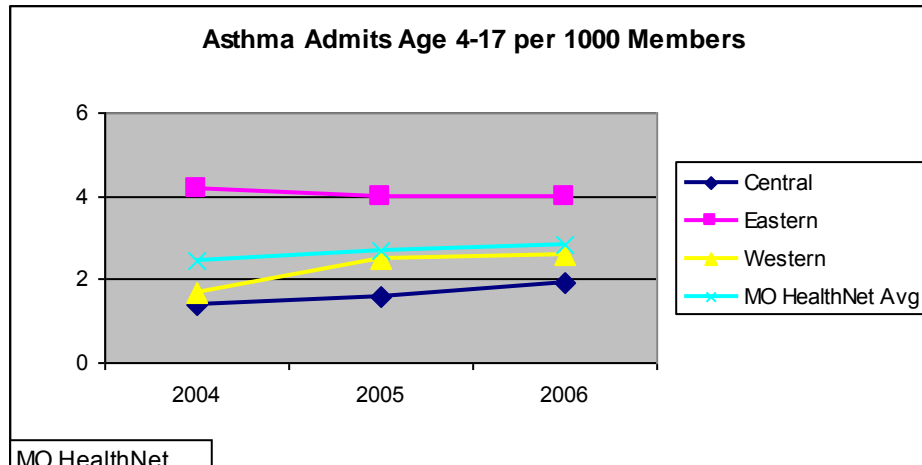
MO HealthNet

Eastern region continues to have a higher rate of asthma admissions than the MO HealthNet average and the other 2 regions. However this rate has trended downward slightly. Central and Western regions continue to trend upward, but remain below the MO HealthNet rate. The Central region's admission rate increased in both age brackets.

Asthma Emergency Room Visits Age 4-17 per 1000 Members
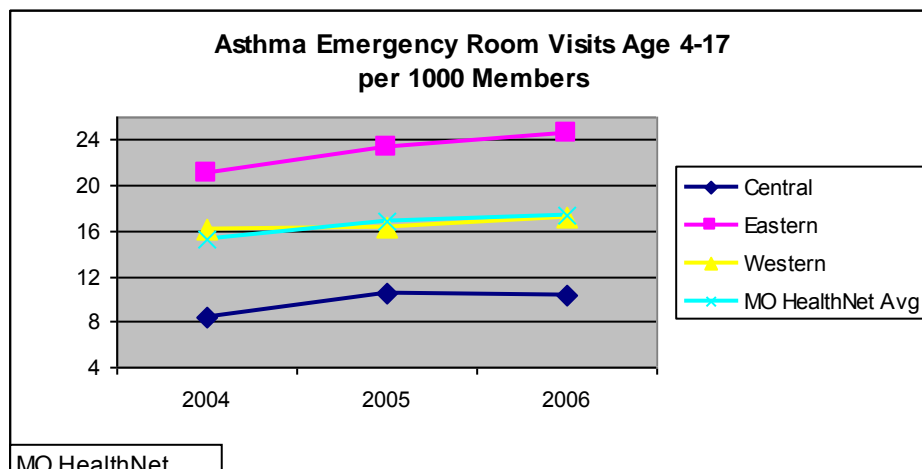
MO HealthNet

The Eastern region ER visit rate for asthma remains above the MO HealthNet average and the Western and Central regions. Central is below the MO HealthNet average.

Asthma Admits Under Age 18 per 1000 Members
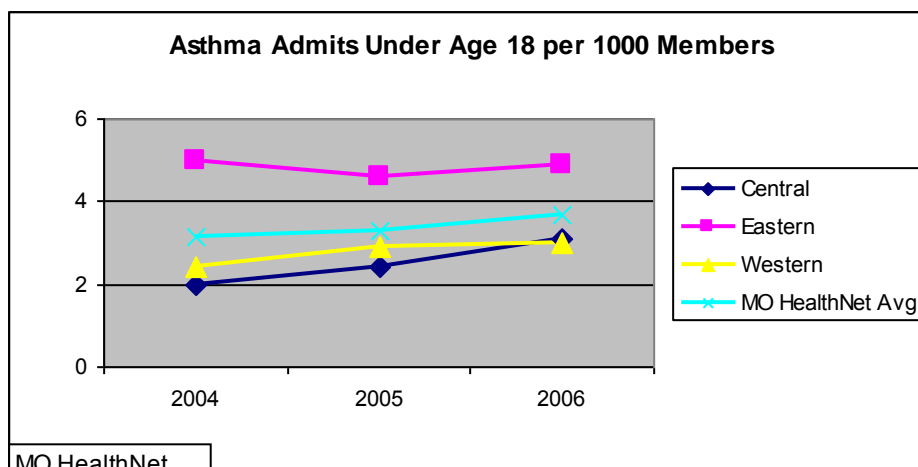
Eastern region's asthma admissions per 1000 members for those under age 18 is above the MO HealthNet average and the other two regions. This is possibly due to the Eastern region's large urban population with a higher asthma prevalence.

Asthma Admits Age 18-64 per 1000 Members
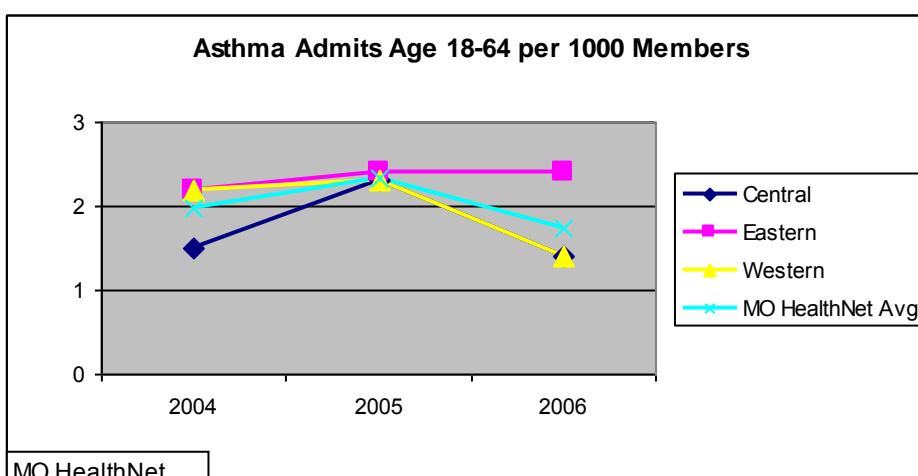
In 2006 the MO HealthNet average decreased along with Central and Western regions, but the Eastern region stayed flat, above the other regions.

Emergency Room Visits Under Age 18 per 1000 Members
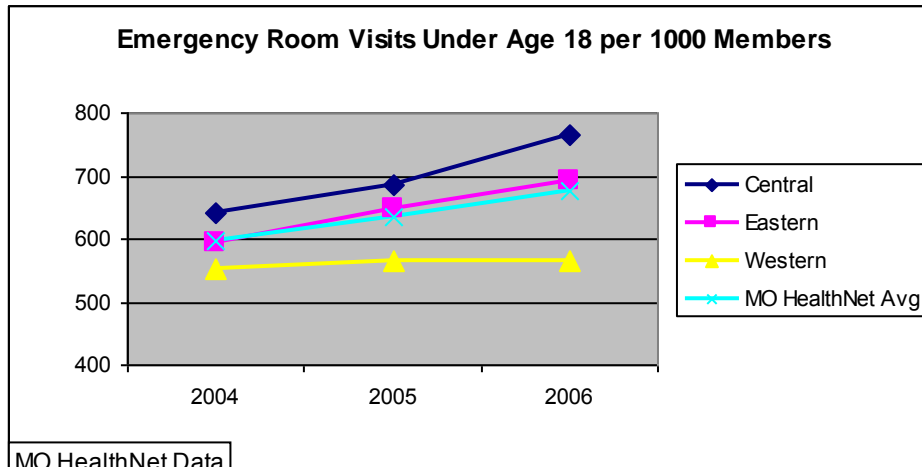
MO HealthNet Data

The rate of Emergency Room visits has increased in Central and Eastern regions, and remained flat in the Western region. Also, the Western region's rate is below the MO HealthNet average, while the Central is above and Eastern is right at the average.

Emergency Room Visits Ages 18-64 per 1000 Members
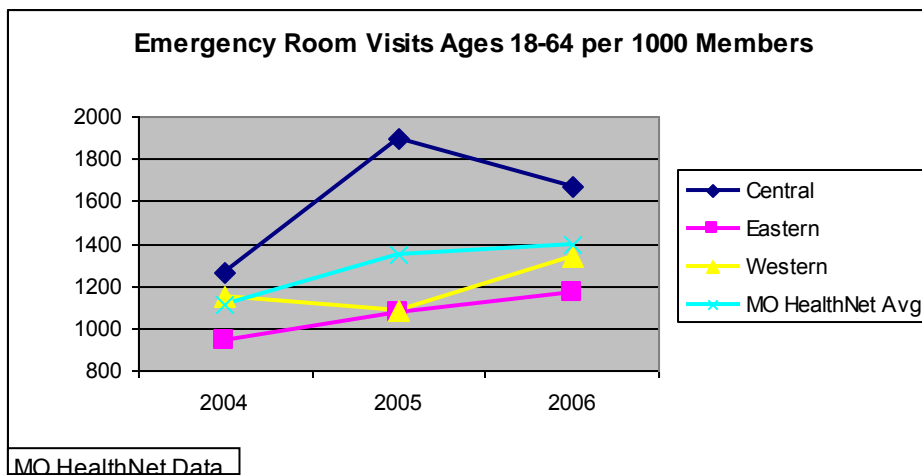
MO HealthNet Data

The rate of Emergency Room visits is higher in the Central region versus the MO HealthNet average and the other regions, even though there was decline from 2005 to 2006.

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births
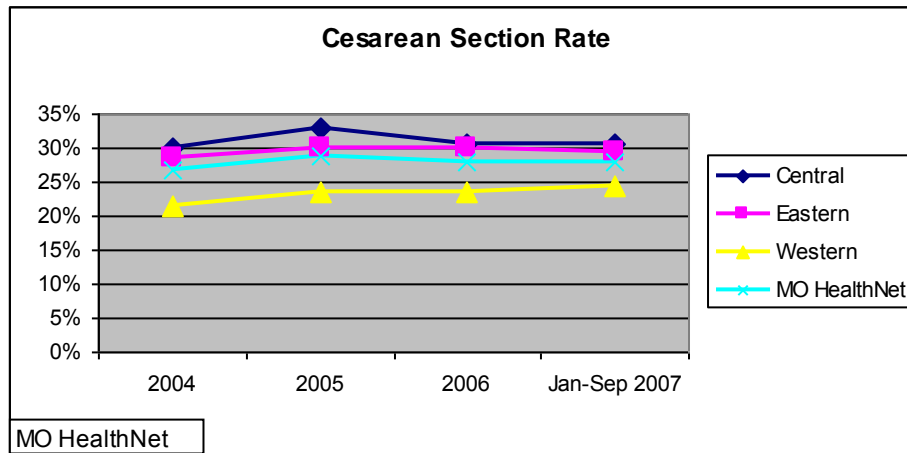
There was no significant change in Cesarean section rates for any region from 2006 to 2007 to date.
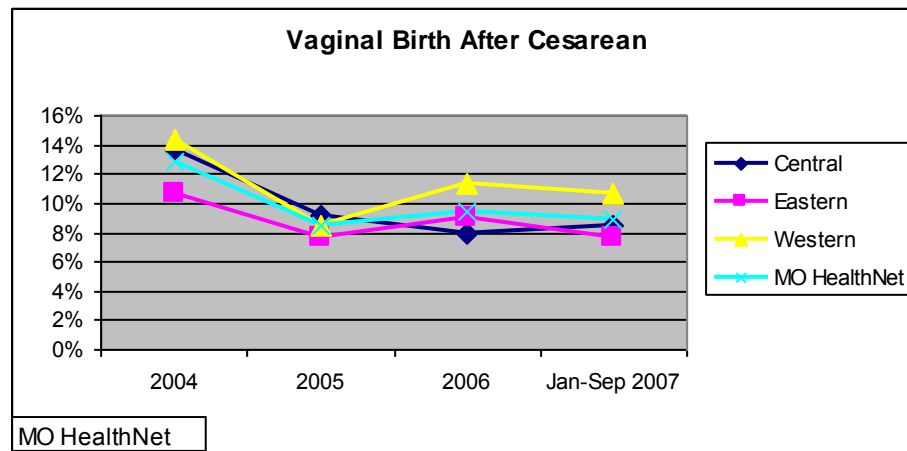
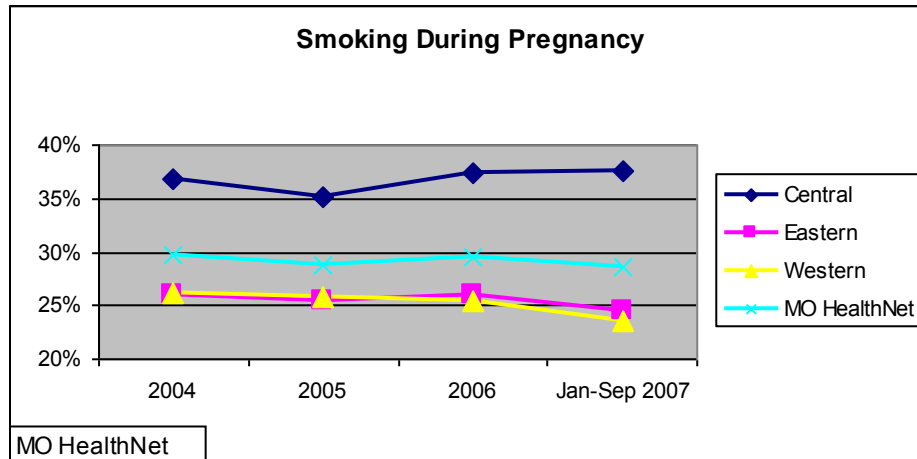There was no significant change in the VBAC rate for any region from 2006 to 2007 to date.

Adequacy of Prenatal Care

MO HealthNet
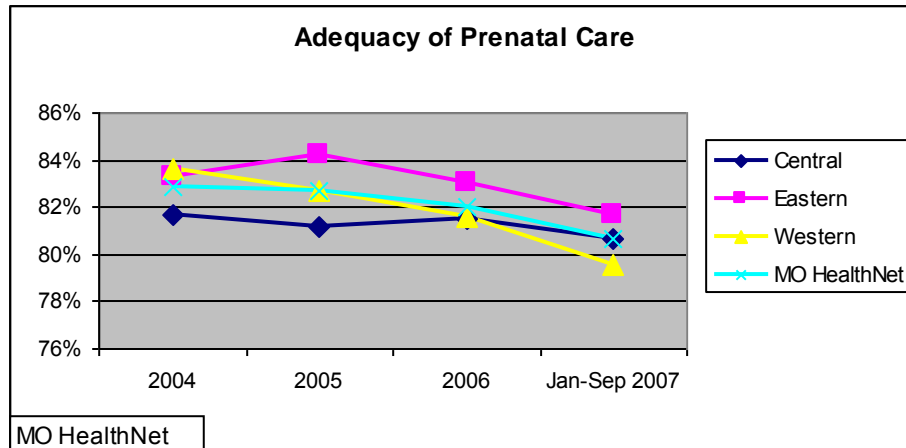
There was decline in all three regions through 2007 to date, consistent with trends for inadequate prenatal care and start of prenatal care in the 2nd trimester.

Low Birth Weight <2500 Grams

MO HealthNet
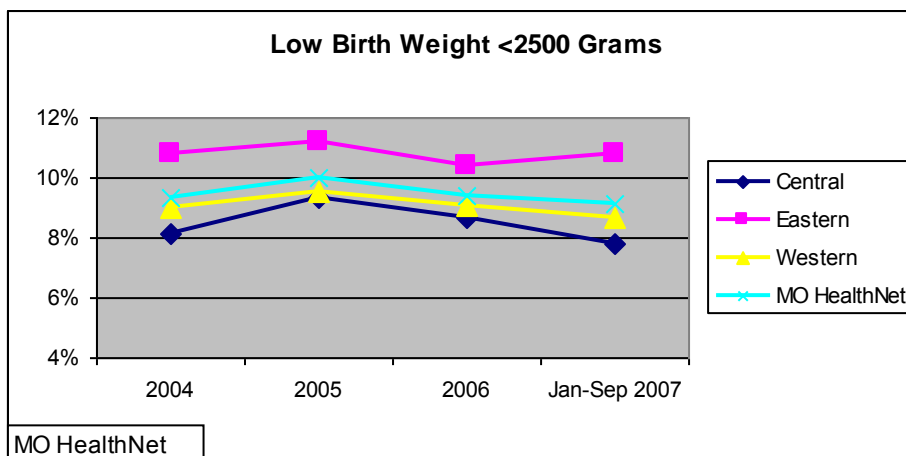
The Eastern region has a higher rate of low birth weight deliveries, showing an increase in 22007. The overall average and the Central and Western regions showed decline since 2005.

Very Low Birth Weight <1500 Grams Not Delivered at Level III Hospital
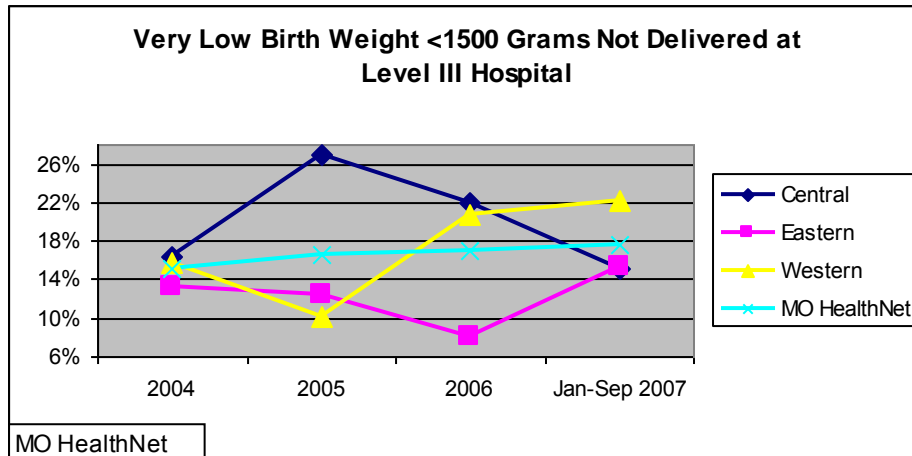
Eastern region saw a significant increase from 2006 to 2007 to date in the rate of VLBW babies born not born at Level III hospitals, after a steep decline from 2005 to 2006. the other two regions so no significant change. Again, Eastern region continues to show significant negative trends overall for prenatal care and deliveries.

Smoking During Pregnancy
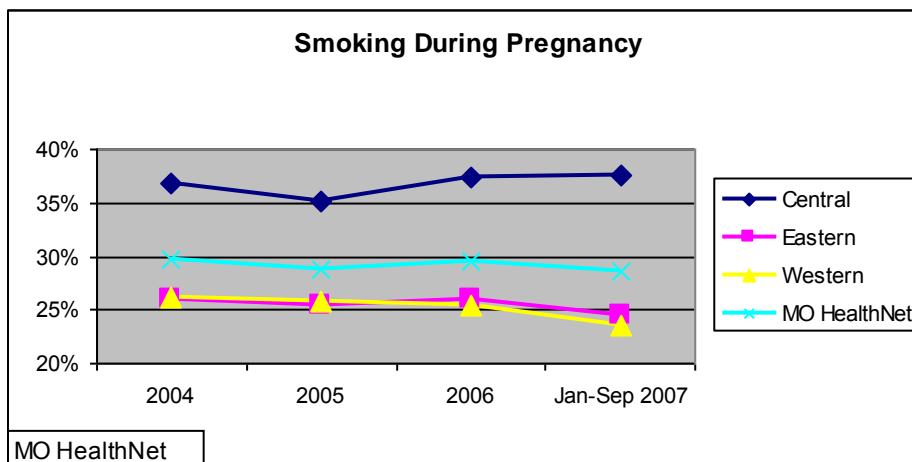
Eastern and Western regions both showed a significant decline in the rate of smoking during pregnancy. Central region remained flat is above the other regions and the MO HealthNet average.

Spacing of Births <18 Months

MO HealthNet
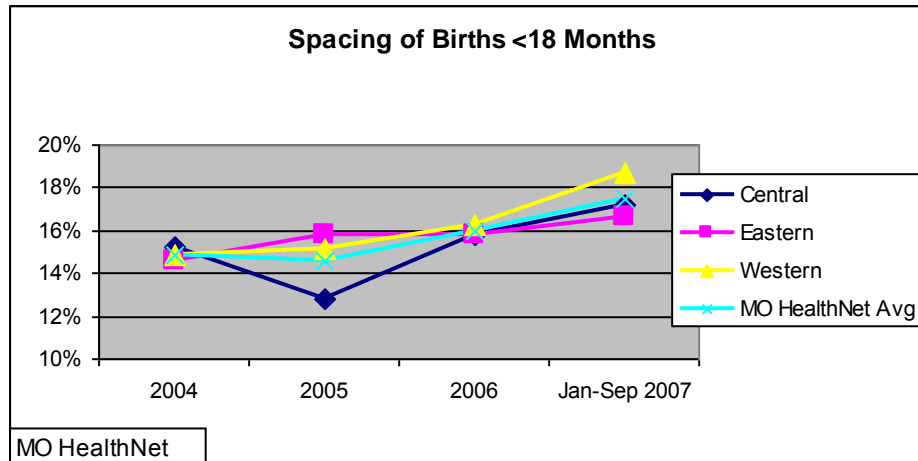
There was a significant increase in Central and Western regions in the rate of deliveries less than 18 months since a prior delivery. Eastern also increased, but not significantly. Potentially an increase in postpartum visits and family planning counseling could help offset this rate climb. HealthCare USA utilized a postpartum member incentive to encourage attending a postpartum visit as prescribed by the members OB care provider. In addition, a provider incentive was created for a postpartum visit.

Births to Moms <18 Years Old

MO HealthNet
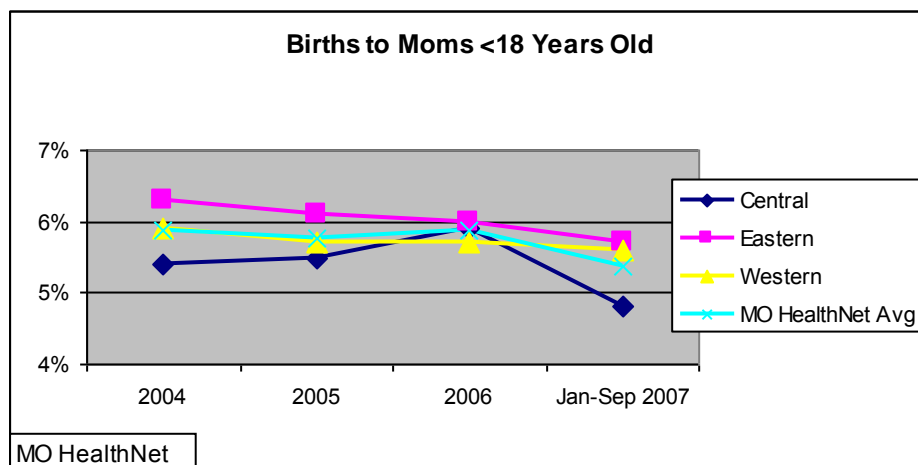
There was a decrease in all 3 regions in the rate of deliveries to moms less than 18 years of age. Even though not significant, it is a positive trend.
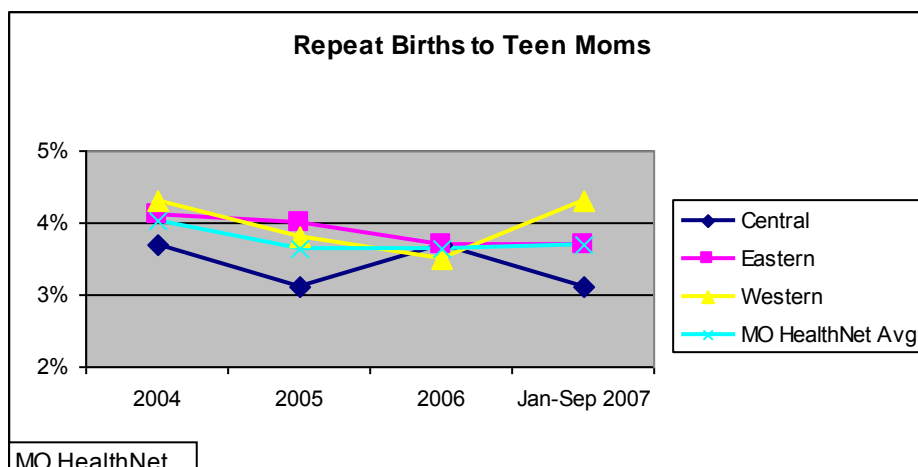
Repeat Births to Teen Moms

MO HealthNet

There was a decrease in the rate of repeat births to teen moms in Central and Eastern regions, but the Western region saw a significant increase in the rate.

Percent of Prenatals on WIC

MO HealthNet
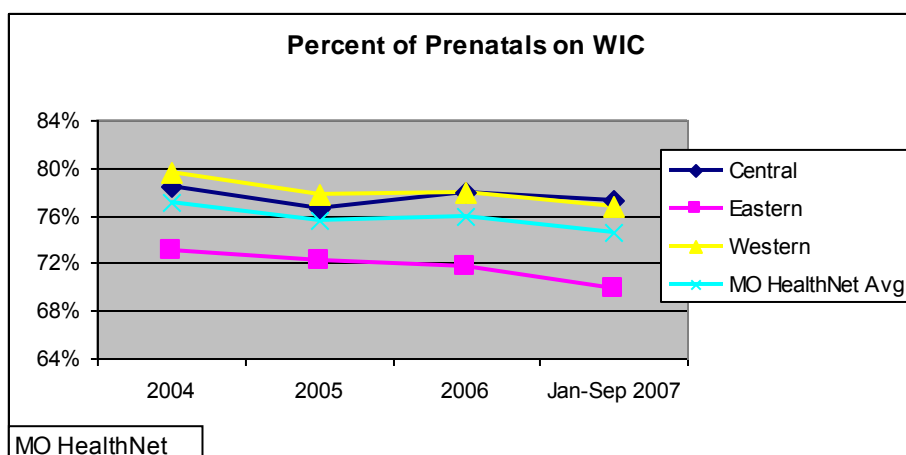
There was a significant decline in the rate of pregnant women on WIC in the Eastern and Central regions. Western region also declined, but not significantly.

Missouri Care

Performance Measures

Missouri Care tracks several performance measures in accordance with MO HealthNet contract requirements. Performance is measured in the following areas: Effectiveness of Care, access/ Availability of Care, Use of Services, and Satisfaction with the Experience of Care.

A new feature added to the report this year are individual measure trend charts, in which Missouri Care's performance is compared against both state and national percentiles over time (Appendix A). The charts present a snapshot of the chronology of interventions implemented, and the corresponding improvements in performance. The health plan reviews these for quality and process improvement planning.

Effectiveness of Care
Missouri Care reports the following HEDIS Effectiveness of Care measures:
- Childhood Immunization Status (CIS- Combo 2 and 3)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Follow-up After Hospitalization for Mental Health Illness (FUH-7 and 30-day)
- Use of Appropriate Medications for People with Asthma (ASM)

Figure 2. HEDIS Effectiveness of Care Measures

	Childhood Immunization - Combo 2	Childhood Immunization - Combo 3	Cervical Cancer Screening	Chlamydia Screening	FU After MH Hosp (7 days)	FU After MH Hosp (30 days)	Appropriate Medication - Asthma
HEDIS 2006	75.18	50.36	73.32	49.44	17.65	47.79	71.09
HEDIS 2007	74.54	64.81	74.59	54.24	42.48	63.16	82.75
HEDIS 2008	75.69	67.92	76.35	53.76	30	67.78	86.96
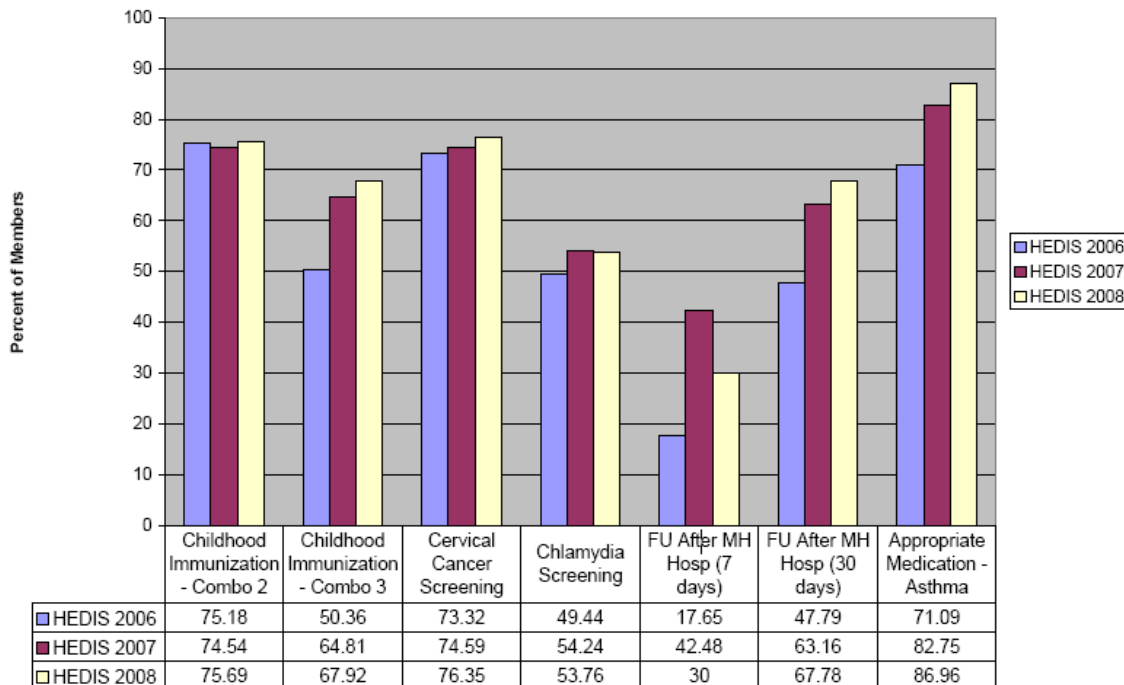
Figure 2 summarizes Missouri Care's performance for HEDIS 2006 through 2008 (measurement years 2005 through 2007). Since HEDIS 2006, Missouri Care improved in all 5 Effectiveness of Care categories, and all 7 of the measures reported here.

There were statistically significant improvements in Childhood Immunizations Combo 3, Chlamydia screening, Follow-up After Mental Health Hospitalization (7- and 30-day), and Use of Appropriate Medications for People with Asthma. Childhood Immunizations Combo 2 remained constant over the past three years; however, the measure improved 10 percentage points between HEDIS 2004 (64%) and HEDIS 2005 (75%), and was 15 percentage points above the statewide average for this measure, before it was retired as a state performance measure.

For HEDIS 2008 Missouri Care's performance on the Cervical Cancer Screening measure remains bestin- state, and at 76.35%, it is just one percentage point lower than the 2008 NCQA HEDIS 90th percentile of 77.42%.

The only statistically significant decline during HEDIS 2008 was observed for the 7-day FUH measure, although Missouri Care's rate of 30% is statistically equivalent to the 2008 HEDIS MO HealthNet managed care average of 36.52%. Another measure that continued to prove challenging for Missouri Care was Chlamydia screening. HEDIS requires reporting for two age groups: members 16-20 years old and 21-25 years old. Missouri Care members in the 21-25 age group tend to be more compliant with this measure than younger members (62.06% vs. 49.86%, respectively). In September 2007, Missouri Care Health Plan initiated a performance improvement project to improve screening rates. A PIP on the FUH measure is in its' third year. Both are described in more detail in the PIP section of this document.

A new Effectiveness of Care prevention measure was created for HEDIS 2008: Lead Screening in Children. It measures the percentage of children two years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday. Missouri Care's rate was 71.43%. Missouri Care follows state guidelines in case management of children with a 10.0 or greater lead level.

Two provider outreach efforts in 2008 targeted lead screening: a section on lead testing in the Preventive Care Toolkit (including Missouri Lead Testing Areas and the HCY Lead Risk Assessment Guide), and a mailing to providers reminding them to test children for lead at 12 and 24 months. Missouri Care is planning a Lead PIP for 2009 that will include both provider and member education and outreach.

Access/Availability of Care
Missouri Care reports the following access/availability of care measures: Timeliness of Prenatal Care (TOPC), Postpartum Care (PPC) and Annual Dental Visits (ADV). Figure 3 depicts Missouri Care's performance between HEDIS 2006 and 2008 (measurement years 2005 through 2007).

Both Prenatal and Postpartum Care rates scored at the NCQA HEDIS 2008 Medicaid 90th percentile. The national 90th percentile for TOPC is 91.4% and for PPC is 70.62%. This is in large part attributable to Missouri Care's strong prenatal and postpartum case management program. Nurses educate members through one-to-one health coaching and provide easily understandable health education materials that promote and support member's prenatal and postpartum self-care.

Access to dental care continues to be a challenge in mid-Missouri. In September of 2008 Missouri Care partnered with a new vendor, Doral Dental. It is hoped that Doral will operate a more effective service.

Figure 3. HEDIS Access/Availability of Care Measures

	Timeliness of Prenatal Care	Postpartum Care	Annual Dental Visit
HEDIS 2006	89.05	66.91	26.76
HEDIS 2007	93.24	71.56	27.76
HEDIS 2008	91.1	70.83	27.5
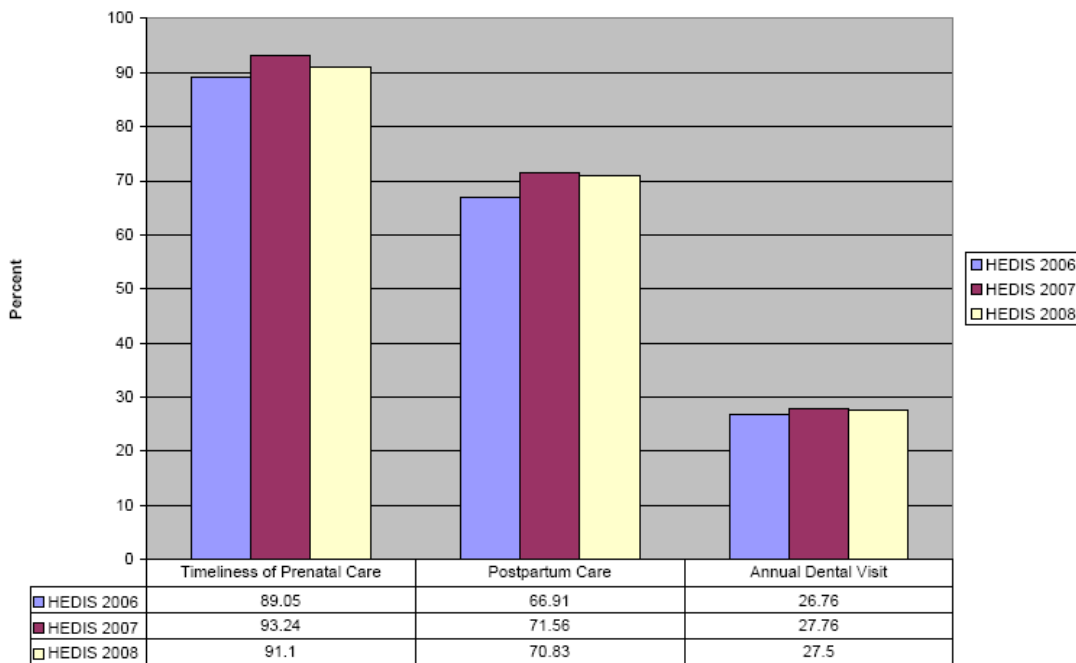
Use of Services

The HEDIS indicators for Use of Services include:
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)
- Adolescent Well Care Visits (AWC)
- Ambulatory Care
- Mental Health Utilization and Identification of Alcohol and Other Drug Services

Figure 4 presents Missouri Care's performance on the Use of Services Well-Child measures between HEDIS 2006 to 2008 (measurement years 2005 through 2007). Well-Child Visits in the First 15 Months of Life (W15) significantly increased in HEDIS 2008 (CY 2007). This measure has been the target of both OB case management and population health improvement initiatives over the past several years, with noticeable results. Baby booklets are sent to all postpartum mothers, along with a checklist that encourages well-child follow-up visits. EPSDT postcards are sent to members according to the periodicity schedule (birth to 21 years) to remind members of needed checkups and to provide age-appropriate health education.

Figure 4. HEDIS Use of Services Measures

	Well Child First 15 months (W15) 6+ Visits	Well Child 3, 4, 5, 6 (W34)	Adolescent Well Care (AWC) 12-21 years
■ HEDIS 2006	72.46	67.37	44.53
■ HEDIS 2007	62.27	58.97	44.91
□ HEDIS 2008	68.63	58.22	49.54
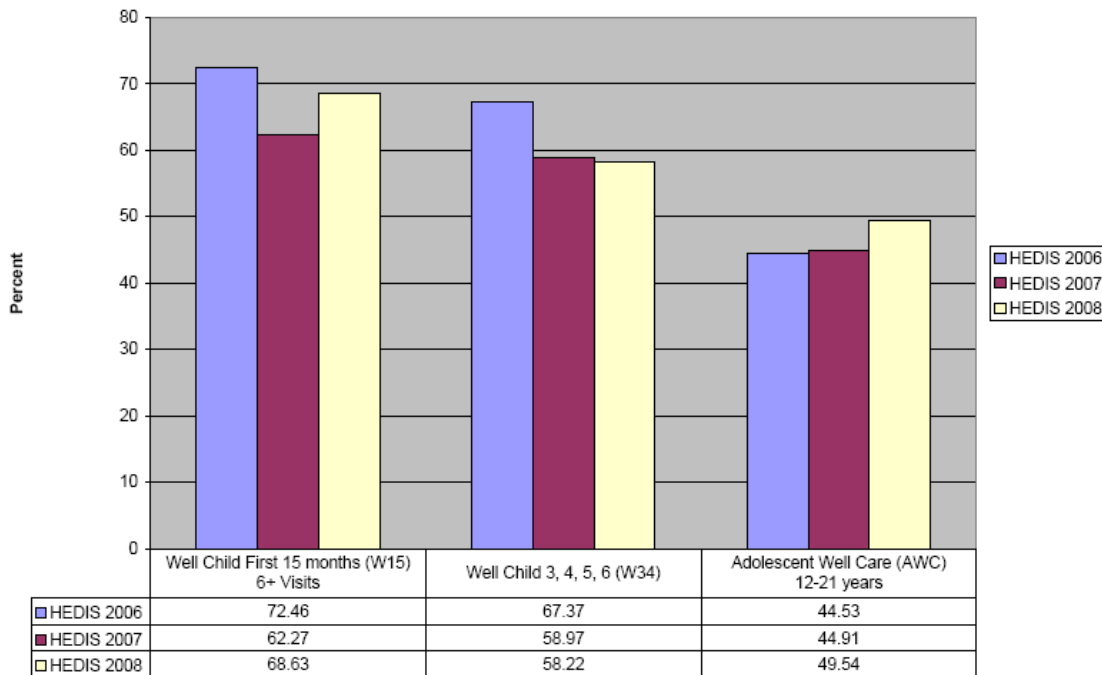
Well-Child Visits at Three, Four, Five, and Six years of age (W34) remained unchanged from HEDIS 2007 to HEDIS 2008. During this same period, the EPSDT participation rate increased from 70.78% to 76.92%. Because of stalled improvement in this age group, Missouri Care has implemented multiple interventions targeting both families and providers over the past three years. The percent of youth aged 12 to 21 years receiving an Adolescent Well-Care check-up did increase by 5 percentage points etween HEDIS 2007 and HEDIS 2008. A summary of the interventions targeting all well-child measures is provided in Appendix A.

The Ambulatory Care HEDIS indicators for HEDIS 2006 through 2008 (measurement years 2005 through 2007) are displayed in Figure 5. Outpatient visits per 1000 member months have increased by 19.6%, or 75 visits per 1000 across the three years, and by 7%, or 29 visits per 1000 over the past year alone. At the same time, ED visits per 1000 member months remained relatively unchanged. This ratio indicates that ED visits are declining as a percentage of all ambulatory care visits. Although Missouri Care did not observe an absolute decrease in ER utilization, an upward trend in use, as seen in outpatient visits per 1000 member months, has been avoided.

145

Figure 5. HEDIS Ambulatory Care Per 1000 Member Months

	Outpatient Visits	Emergency Department Visits	Ambulatory Surgery/Procedures	Observation Room Stays Resulting in Discharge
HEDIS 2006	379.73	76.26	7.36	3.52
HEDIS 2007	425.43	75.99	5.94	1.8
HEDIS 2008	454.31	78.31	5.45	2.03
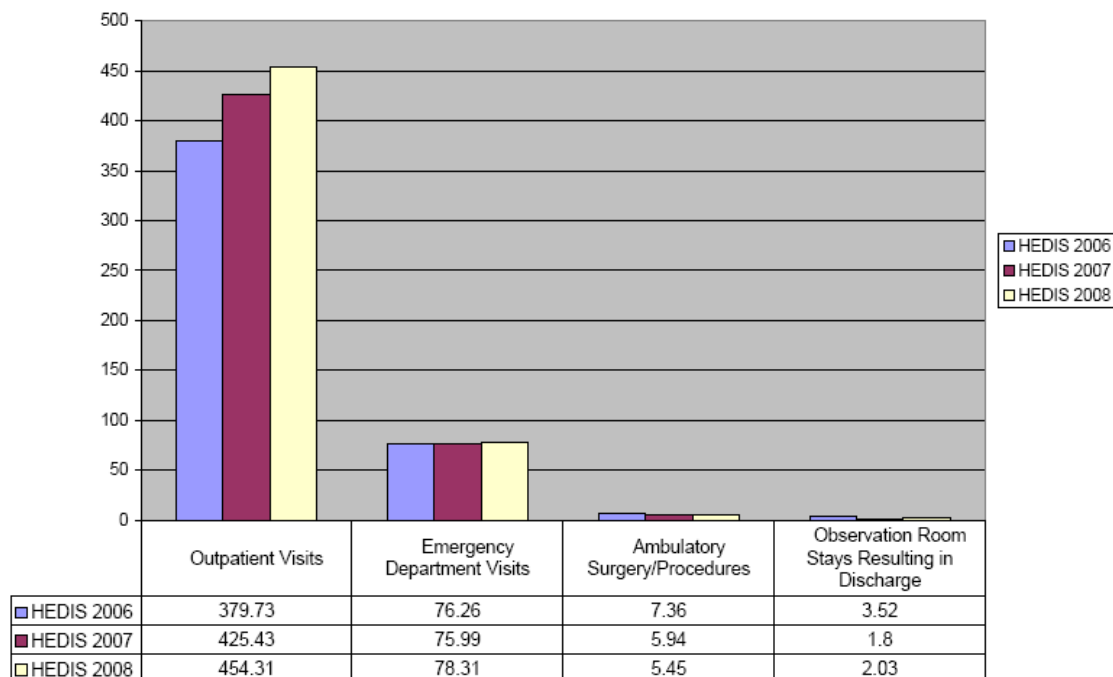
The ED rate of 78.31 visits per 1000 member months places the health plan between NCQA's HEDIS 75th and 90th percentiles for the Medicaid population. For this measure, higher is *not* better. Although Missouri Care's ED visit rate has been stable over the past 3 years, it compares poorly against national rates, confirming the need for ongoing focus and improvement.

Ambulatory surgery/procedures decreased from 7.36 per 1000 member months for HEDIS 2006 to 5.45 per 1000 for HEDIS 2008. Observation room stays resulting in discharge declined by 49% between HEDIS 2006 and HEDIS 2007, and have remained low in HEDIS 2008.

Mental Health Utilization and Identification of Alcohol and Other Drug Services
The 2006, 2007 and 2008 HEDIS rates for Mental Health Utilization are charted in Figure 6. There was a slight decrease in ambulatory mental health services in the most recent year's data. Rates for inpatient mental health services and alcohol and other drug services have remained low and stable over the past three years The Identification of Alcohol and Other Drug Services was reported for the first time in HEDIS 2007.

Figure 6. HEDIS Mental Health Utilization and Identification of Alcohol and Other Drug Services

	Any Mental Health Services	Inpatient Mental Health Services	Ambulatory Mental Health Services	Alcohol and other Drug Services
■ HEDIS 2006	9.93	0.58	9.79	
■ HEDIS 2007	11.15	0.82	10.98	1.42
□ HEDIS 2008	10.45	0.78	10.34	1.42
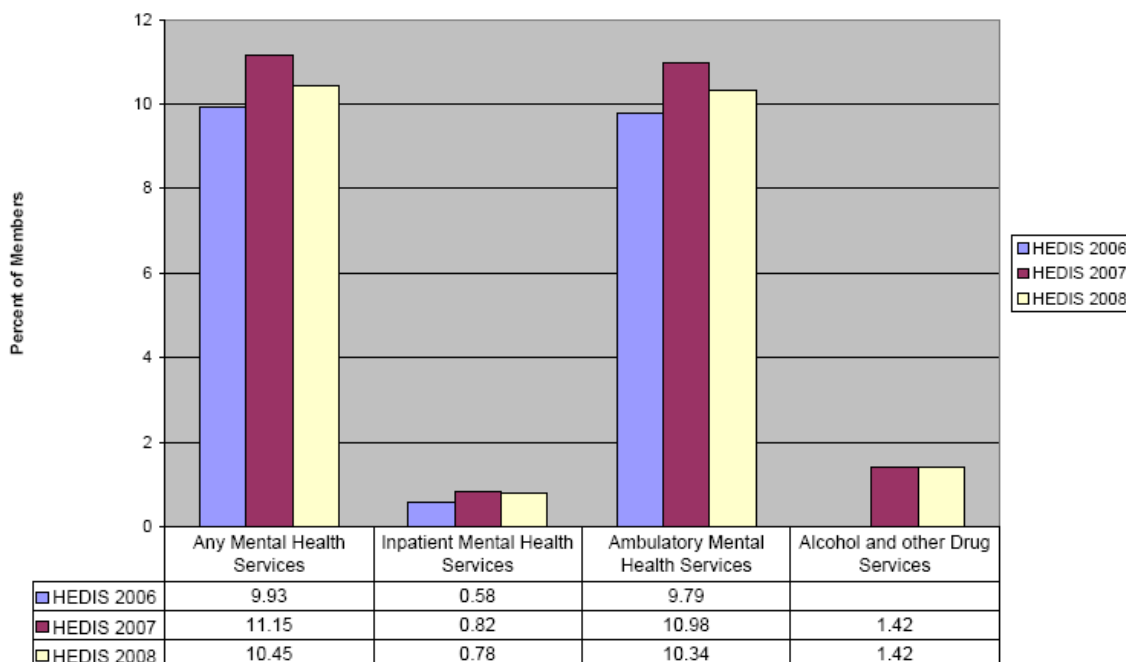
CAHPS Survey

Composite results of the CAHPS 3.0H Medicaid Child Survey are presented in Table 1. Using a scale of *0* to *10,* where *0* is the ―worst possible‖ rating and *10* is the ―best possible‖ rating, respondents were asked to rate their child's personal doctor or nurse, the specialist their child saw most often, all health care their child received, and their child's health plan. A total of 1,650 eligible members of Missouri Care Health Plan were randomly selected for this study. The final survey response rate was 26.5 percent.

Member satisfaction was highest in the following composite categories (ratings were an *8, 9* or *10*):
- Courteous and Helpful Staff (92.5%)
- How Well Doctors Communicate (91.7%)
- Getting Care Quickly (81.4%)
- Getting Needed Care Quickly (80.1%)

There were no significant changes in the composite ratings from CAHPS 2006 to CAHPS 2008. Several of the composite measures included sub-questions. From 2006 to 2008 there was a significant increase in members reporting they were able to get care as quickly as they wanted for an illness, injury or condition (from 75% to 89.3%, respectively).

Table 1. CAHPS 3.0H Medicaid Child Survey Rates

Composite/Rating Areas	CAHPS 2006	CAHPS 2007	CAHPS 2008
Getting Needed Care	79.4%	81.4%	80.1%
Getting Care Quickly	76.7%	81.3%	81.4%
Courteous and Helpful Office Staff	94.9%	92.0%	92.5%
How Well Doctors Communicate	90.9%	91.9%	91.7%
Customer Service	70.9%	79.3%	69.5%
Rating of Personal Doctor or Nurse	76.7%	78.4%	79.9%
Rating of Specialist	69.2%	76.4%	76.1%
Rating of All Health Care	78.3%	79.6%	77.6%
Rating of Health Plan	73.1%	77.5%	75.5%

The Customer Service composite measure decreased significantly between CY 06 and CY 07. Figure 7 displays Missouri Care's 3-year trend, as compared to the statewide average.

Figure 7: Customer Service Composite Measure
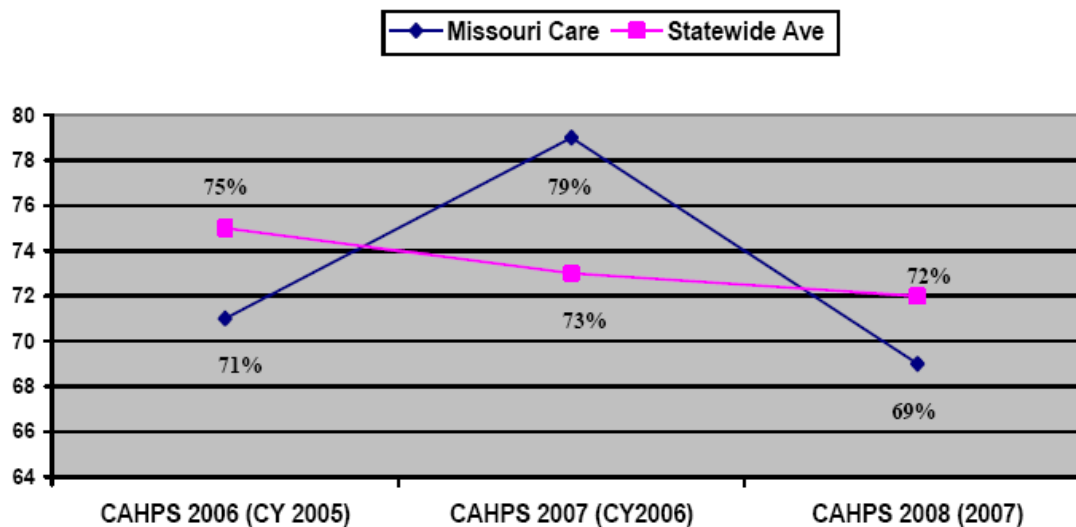
There were two sub-questions for this measure:

- Q53: *In the last 6 months, how much of a problem, if any, was it to find or understand this information?* This question was in reference to Q52: *In the last 6 months, did you look for any information about how your child's health plan works in written materials or on the Internet?*

- Q55: *In the last 6 months, how much of a problem, if any, was it to get the help you needed when you called your child's health plan's customer service?*

The overall ratings decline was a result of a poorer score on Question 53, rather than 55. This is an opportunity for improvement in 2009, although the Missouri Care rate was only 3 percentage points lower than the statewide average. Of note was a change in survey vendors between CY 2006 and 2007 (from the Myers Group to the Center for the Study of Services), which may have resulted in implementation or measurement variation. Missouri Care plans to review all of its' written and online member education materials in 2009.

Trends in MO HealthNet Quality Indicators

Missouri Care requires that all facilities complete and submit a Birth Notification within one business day of a member's delivery. This allows for tracking and reporting of all birth outcomes. In this reporting period, Missouri Care received notification of 2,264 deliveries and 2,285 newborns. 91% of newborns were born at 37 weeks or greater. 9% of newborns were born less than 37 weeks. Average gestational age of newborns was 38 weeks. 23 newborns weighed less than 1500 grams (1.01%), 170 weighed 1500 to 2500 grams (7.44%), and 2,078 weighed 2500 or more grams (90.94%). Missouri Care's c-section rate remained stable at 28% for this reporting period. Missouri Care supports the Healthy People 2010 objective to reduce preterm births with a target of 7.6%, Low birth weight of 7.6% and Very low birth weight of 1.4%. Missouri Care has partnered with the Rosebud Program to assist in improving health outcomes and reducing costs associated with high risk pregnancies and infants. Rosebud's experienced perinatal and neonatal nurse consultant's work in collaboration with Missouri Care's Perinatal Case Manager to support the member's plan of care.

MoHealthNet tracks the following maternal child health indicators to evaluate the health status of the MO HealthNet population. Table 2 and 3 compares Missouri Care to the other plan(s) within the central region. No significant trends were noted.

Table 2. Trends in Missouri Medicaid Quality Indicators (Secondary Source Reporting)						
		CY 2006 Births	Percent of total births	Jan-Sept 2007 Births	Percent of total births	Sig. Chg.
1	**Trimester Prenatal Care Began**					
	a. First	2,515	77%	1,877	76.8%	No
	b. Second	644	19.7%	493	20.2%	No
	c. Third	88	2.7%	65	2.7%	No
	d. None	21	0.6%	10	0.4%	No
	e. Total	3,268		2,445		
2	**Inadequate Prenatal Care**	575	18.5%	447	19.3%	No
3	**Birth Weight (grams)**					
	a. < 500	3	0.1%	4	0.2%	No
	b. 500-1499	38	1.1%	29	1.1%	No
	c. 1500-1999	59	1.7%	31	1.2%	No
	d. 2000-2499	211	5.90%	142	5.4%	No
	e. 2500+	3,251	91.3%	2,430	92.2%	No
	f. Total	3,562		2,636		

		CY 2006 Births	Percent of total births	Jan-Sept 2007 Births	Percent of total births	Sig. Chg.
4	**Low Birth Weight (<2500 grams)**	311	8.7%	206	7.8%	No
5	**Method of Delivery**					
	a. Cesarean Section	1,086	30.5%	804	30.5%	No
	b. VBAC	42	1.2%	35	1.3%	No
	c. Repeat C-Section	493	13.8%	379	14.4%	No
	d. Vaginal	1,942	54.5%	1,420	53.8%	No
	e. Total	3,563		2,638		No
6	**Smoking During Pregnancy**	1,332	37.4%	991	37.6%	No
7	**Spacing < 18 mos since last birth**	315	15.8%	255	17.2%	Yes
8	**Births to mothers < 18 years of age**	210	5.9%	126	4.8%	No
9	**Repeat Teen Births**	133	3.7%	83	3.1%	No
10	**Fetal Deaths (20+wks)**	27	7.6%	17	6.4%	No
11	**Total live births or stillborn fetuses 500 grams or more**	3,576	212.8%	2,638	214.1%	Yes
12.	**Percent of prenatals on WIC**	2,780	78%	2,037	77.2%	Yes
13	**VLBW not delivered in level III hospitals**	9	22%	5	15.2%	No
14	**Average maternal length of stay (days) Inpatient admissions**	3,176	2.50%	N/A		
15	**Average behavioral health length of stay (days) Inpatient admissions**	208	9.8%	N/A		
16	**Asthma inpatient admissions ages 4-17 Inpatient admissions**	56	1.9%	N/A		
17	**Asthma emergency room visits ages 4-17**	302	10.4%	N/A		
18	**Asthma admissions under age 18 Inpatient admissions**	129	3.1%	N/A		
19	**Asthma admissions ages 18-64**	13	1.4%	N/A		
20	**Emergency room visits under age 18**	31,450	765.7%	N/A		
21	**Emergency room visits ages 18-64**	16,036	1670.4%	N/A		

		CY 2006 Births	Percent of total births	Jan-Sept 2007 Births	Percent of total births	Sig. Chg.
22	Hysterectomies	57	7.5%	N/A		
23	Vaginal hysterectomies	28	49.1%	N/A		
24	Preventable hospitalization under age 18	534	13%	N/A		

***Statistically significant change between CY2006 and Jan-Sept 2007 at .05 level of significance using Chi-square test. Source: Missouri Department of Health and Senior Services

HEDIS Indicators by Missouri MO HealthNet Managed Care Plans within Regions; Live Births

Table 3: HEDIS Indicators by Missouri MO Health Net Managed Care Plans (Secondary Source Reporting)				
Indicator	HEDIS 2007	HEDIS 2006	HEDIS 2005	Total Deliver-ies*
Method of Delivery				
Cesarean Section				
Missouri Care	29.1	28.3	31	1,999
Central Region Total	31.2	29.9	33.9	3,284
Vaginal Birth after Cesarean Section				
Missouri Care	8.1	10	11.7	298
Central Region Total	6.6	8.1	8.7	531
Total Deliveries = Total live births with Live Births with VBAC or Repeat C-Section noted				
Adequate Prenatal Care				
Missouri Care	81.8	82.3	82.7	1,735
Central Region Total	82.6	83.5	83.5	2,884
Total Deliveries = Total live births with known prenatal care				
Early Prenatal Care				
Missouri Care	73.5	73.6	76.7	302
Central Region Total	75.2	77.9	79.5	505
Total Deliveries = Total live births to continuously enrolled women up to 289 days prior to delivery One gap of up to 45 days was allowed				
Low Birth Weight (< 2500 gms)				
Missouri Care	9.2	8.7	6.7	271
Central Region Total	9.7	8.8	9.3	463
Total Deliveries = Total live births to continuously enrolled women for 12 mos prior to delivery One gap of up to 45 days in the 175 days to delivery was allowed				

Indicator	HEDIS 2008	HEDIS 2007	HEDIS 2006	Total Deliveries*
LBW delivered in Level II/III hospital				
Missouri Care	80.5	75.8	73.4	149
Central Region Total	78.9	76.5	76.8	270
Total Deliveries =Total live births with birth weight less than 2500 gms				
VLBW delivered in Level II/III hospital				
Missouri Care	90.9	84.2	87.5	22
Central Region Total	91.7	81.6	84.6	48
Total Deliveries =Total live births with birth weight less than 1500 gms				
Smoking during Pregnancy				
Missouri Care	38.4	40.2	36	1,999
Central Region Total	36.5	38.4	34.5	3,284
Total Deliveries = Total live births				
Spacing < 18 months				
Missouri Care	16.0	15.1	12.2	1,075
Central Region Total	16.3	14.9	13.1	1,821
Total Deliveries =Total second or higher order live births with know spacing				
Births to mothers < 18 y/o				
Missouri Care	5.7	6.5	6.2	1,999
Central Region Total	5.2	6.4	6.2	3,284
Total Deliveries = Total live births				
Repeat births to teen mothers				
Missouri Care	3.7	3.2	2.4	1,999
Central Region Total	3.4	3.6	3.0	3,284
Total Deliveries = Total live births				
Prenatal WIC participants				
Missouri Care	78.1	78.4	77.7	1,986
Central Region	76.9	77.7	74.5	3,209
Total Deliveries = Total live births with known WIC participant				

Source: Missouri Department of Health and Senior Services

Molina Healthcare of Missouri

Performance Measures
MHMO monitors performance on a monthly basis. The performance measures are presented to the QIC and the Quality sub-committees for analysis, review, identification of trends, recognition of goal achievement, and establishment of corrective actions.

The performance measures are divided into three categories:
Customer Service indicators are focused on membership activity, phone metrics, and timeliness of claims payment.

Quality Improvement indicators focus on provider complaints, grievances and appeals, member grievances and appeals and credentialing.

Medical Management indicators are focused on authorization and referral calls, days/1000, obstetrics and utilization management.

Trends in MO HealthNet Quality Indicators

The following HEDIS data was reported to DHSS for MHMO in all Missouri Regions (Eastern, Western and Central).

	Reported Rate Eastern Region	Reported Rate Western Region	Reported Rate Central Region
Childhood Immunization: DTP	69.10%	*	*
Childhood Immunization: MMR	87.35%	*	*
Childhood Immunization: IPV/OPV	84.18%	*	*
Childhood Immunization: Hib	85.16%	*	*
Childhood Immunization: Hepatitis B	84.91%	*	*
Childhood Immunization: VZV	85.64%	*	*
Childhood Immunization: Pneumococcal Conjugate	63.26%	*	*
Childhood Immunization: Combo 3	54.01%	*	*
Childhood Immunization: Combo 2	63.75%	*	*
Adolescent Well-Care Visits	43.55%	17.83%	8.57%
Use of Appropriate Meds for People w/ Asthma: 5-9 years old	85.08%	*	*
Use of Appropriate Meds for People w/ Asthma: 10-17 years old	84.51%	*	*
Use of Appropriate Meds for People w/ Asthma: 18-56 years old	80.95%	*	*
Use of Appropriate Meds for People w/ Asthma: combined	84.16%	*	*
Chlamydia Screening: 16-	47.86%	*	*

20 years old			
Chlamydia Screening: 21-25 years old	52.71%	*	*
Chlamydia Screening: combined	49.80%	*	*
Cervical Cancer Screening	46.57%	25.45%	*
Annual Dental Visits: 2-3 years old	9.01%	16.67%	*
Annual Dental Visits: 4-6 years old	33.76%	14.08%	*
Annual Dental Visits: 7-10 years old	41.74%	19.10%	*
Annual Dental Visits: 11-14 years old	35.97%	13.83%	*
Annual Dental Visit Total	30.75%	15.16%	13.93%

*N/A Denominator fewer than 30

HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births
The following HEDIS data was reported to MHD for MHMO in all Missouri Regions (Eastern, Western and Central).

	Reported Rate Eastern Region	Reported Rate Western Region	Reported Rate Central Region
Well Child Visits in the first 15 Months of Life: 0 visits	4.38%	*	*
Well Child Visits in the first 15 Months of Life: 1 visit	7.79%	*	*
Well Child Visits in the first 15 Months of Life: 2 visits	10.95%	*	*
Well Child Visits in the first 15 Months of Life: 3 visits	11.68%	*	*
Well Child Visits in the first 15 Months of Life: 4 visits	14.60%	*	*
Well Child Visits in the first 15 Months of Life: 5 visits	18.25%	*	*
Well Child Visits in the first 15 Months of Life: 6 or more visits	32.36%	*	*

Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	50.94%	34.04%	42.55%
W/in 7 Days of Discharge Mental Illness Hospital	31.05%	*	*
W/in 30 Days of Discharge Mental Illness Hospital	52.62%	*	*
Timeliness of Prenatal Care	78.35%	59.78%	*
Postpartum Care	54.74%	51.09%	*

*N/A Denominator fewer than 30

CAHPS
The following CAHPS data was reported to NCQA for MHMO in the Eastern and Western Regions. Due to the estimated low response rate, as calculated by MHMO's CAHPS vendor, a CAHPS survey was not conducted in the Central Region.

	Reported Rate Eastern Region	Reported Rate Western Region
Health Plan Overall	78.5%	62.9%
Health Care Overall	80.8%	69.9%
Personal Doctor Overall	84.5%	71.7%
Specialist Overall	88.2%	76.9%
Customer Service	75.5%	59.8%
Getting Needed Care	79.7%	64.6%
Getting Care Quickly	77.7%	67.9%
How Well Doctors Communicate	90.0%	84.9%
Courteous and Helpful Office Staff	92.0%	91.1%

This page intentionally left blank.

Accessibility of Services

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Average Speed of Answer
Call Abandonment Rate
Telephone accessibility to members is monitored for call abandon rate and call wait time in queue (average time to answer). Performance is reported regularly to the BA+ Oversight Committee and Quality Council with recommendations for action when standards are not met.

During FY2008, an average of 3,578 calls was received each month with an average membership of 27,700.

With the average speed to answer goal of no greater than 30 seconds during FY2008, callers waited an average of 30 seconds.

The goal for abandonment rate is not greater than 5%. In FY2008, the abandonment rate was 4.0%. Abandon rate varied between 1.7 to 6.9% by month.

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
Call Wait Time (Goal: 30 seconds)	28.0	27.0	17	49	38	34	45	45	23	29	19	17
Call Abandon Rate (Goal: 5%)	4.5%	3.9%	2.8%	6.9%	4.6%	4.1%	5.6%	5.9%	2.9%	3.4%	1.7%	1.9%
Calls Received	3368	3906	3072	3343	3962	2925	4171	4144	3562	4021	3342	3127
Calls Handled	3187	3713	2972	3040	2781	2771	3882	3831	3422	3843	3255	3060

Non-Routine Needs Appointments
Routine Needs Appointments
BCBSKC maintains standards for appointment access for BA+ members to their primary care physician. These standards are formally developed and updated each year under the direction of the Quality Council.

BCBSKC-BA+ monitors member access to their physician in one or more of the following ways:
a. Appointment access - member complaints.

b. CAHPS questions regarding the member's access to routine, urgent and emergent care.

c. After-Hours Access Performance Analysis for Members annual report.

As part of the monitoring process, 86% of primary care physician offices were called by a Blue Cross and Blue Shield of Kansas City representative from the Quality Management Department. 329 primary care physician offices were called after business hours to assess compliance with the standard.

Access to Emergent and Urgent Care
Urgent Care Access – Urgent Care is available to members through many sources. BCBSKC has contracts with Take Care Health and Minute Clinics, as well as some provider offices to provide urgent care services for BCBSKC-BA+ members. BA+ continues to provide communication to members on how and where to find an urgent care center.

Emergent Care Access – Members are informed of emergent care centers in the Member Handbook. The Member Handbook contains information on how to access emergent care. In FY2008, BA+ members accessed emergent care 22,564 times. The HMO and PPO Appointment and Access Availability Standards are provided to providers annually through the Physician Office Guide.

Network Adequacy – Provider/Enrollee Ratios
BA+ has positively affected the healthcare status of MO HealthNet Members by providing ongoing monitoring of BCBSKC provider networks. BCBSKC monitors geographic availability, open panels, and appointment access.

2007 Analysis of Blue-Advantage Plus Geographic Network Availability

Purpose:
This evaluation is designed to assess geographic availability for Primary Care Physicians (PCP) and high volume specialties of Obstetrics (OB/GYN), Cardiologists, and Orthopedic Surgeons by BCBSKC members enrolled in BA+.

Conclusions:
BA+'s geographic network availability meets or exceeds performance standards for all availability standards measures, as detailed below:

a. The overall ratio of members to BA+ Primary Care physicians continues in 2007 to be well below the 500/1 ratio established by BCBSKC availability standards.

b. The percentage of members within the urban (Kansas City metro) area having access to at least two (2) Primary Care Physicians within an ten (10) mile radius exceeds the 90% urban standard performance goal for BA+ network.

c. The percentage of members within the basic/non-urban (suburban) service area having access to at least two (2) Primary Care Physicians within a twenty (20) mile radius exceeds the 90% basic/non-urban standard performance goal for the BA+ network.

d. The percentage of members within the rural service area having access to at least two (2) Primary Care Physicians within a thirty (30) mile radius exceeds the 90% rural standard performance goal for the BA+ network.

e. The percentage of women members 18 years old but less than 64 years of age within the urban, basic, and rural service areas having access to at least one (1) OB/GYN is well above the 90% standard performance goal for the BA+ network.

f. The percentage of members within the urban, basic, and rural service areas having access to at least one cardiologist and one orthopedic surgeon is 100% for all networks, well above the 90% standard performance goal for this high-volume specialty for all the BA+ network.

2008 Analysis of Open Practices Availability Standards Performance for BA+
BA+ evaluates the availability of PCPs with open practices. For 2008, 67% of PCP's are accepting new patients. BA+ did not meet the goal of 70%. In order to address this issue, Physician Services will analyze the PCP practices in BA+ with closed panels and contact those practices in an attempt to encourage them to re-open their panels.

24 Hour Access/After Hours Availability
BA+ provides a Nurse Advice Line to members 24 hours per day/7 days per week. This Nurse is available to direct members to receive care within the network. The nurse phone line also forwards reports on a weekly basis to the BCBSKC Case Management Department for any pregnant caller. These reports are then reviewed by the prenatal nurse coordinator for opportunities to enroll these members in the Little Stars Prenatal Program or refer them for more individualized follow-up by a case manager. The Nurse Advice Line may offer BA+ members the assistance that they need without having to incur an emergency room visit. In FY2008, 1,308 individual members utilized the Nurse Advice Line.

For FY2008, BA+ has not received any complaints from members in regards to accessing services after hours. BA+ maintains policies and procedures that assist with the timeliness of requests for services.

Open/Closed Panels
BCBSKC/BA+ conducts annual geographic analysis of physician networks. To be compliant with BCBSKC standards, this analysis should show that at least 90% of members have access to at least two primary care physicians (PCPs) within 10 miles for members in the urban service area, within 20 miles for members in the basic service area, and within 30 miles for members within the rural service area. The most recent analysis in 2008 found the standards were met, with 100%, 99.8%, and 99.5%, respectively, of members having access to at least two PCPs in the three measurement areas.

In addition, BCBSKC monitors the ratio of members to physicians. Below are the standards and BA+'s results for 2008.

	PCP			OB/GYN			Cardiology			Orthopedics		
			Members PER Physician			Members PER Physician			Members PER Physician			Members PER Physician
Plan Name	Members	Physicians	RATIO	*Members	Physicians	RATIO	Members	Physicians	RATIO	Members	Physicians	RATIO
HMO Standard			500			1,000			1,000			1,000
BA+	28,673	353	81.23	4,840	115	42.09	28,673	92	311.66	28,673	34	843.32

* Population includes only women over 18 and under 64.

Cultural Competency

Cultural Competency Activities – New Directions Behavioral Health (NDBH) has been involved in the promotion of cultural competency for BCBSKC's provider networks since 2000 by promoting workshops and presentations for area health care professionals.

In 2007, New Directions collaborated with two other organizations to present a culturally focused 4-hour workshop featuring a nationally recognized cognitive behavioral therapist.

In 2008, New Directions presented several small workshops on cultural competency topics such as suicide awareness across population mixes, bullying and violence in school settings, and a major four hour workshop "Family Clinical Interventions for Adolescent Suicidality with Special Emphasis on Latinas: A Cultural Competency Perspective.

Provider Network Composition – The BA+ network is 60% female. The Missouri Standard Credentialing Application does not support providing information about the ethnic background of providers. Providers do include the primary language spoken: Within the BA+ network, there are 982 providers and 62 speak languages other than English.

Requests to Change Practitioners

BA+ has established a standard operating procedure to allow a member to change their primary care provider. Children in COA 4 are allowed to change primary care providers as often as needed. The process to change primary care providers is published in the Member Handbook. Standard operating procedures help guide staff in assisting a member who wants to change their primary care provider.

Children's Mercy Family Health Partners

Average Speed of Answer

Children's Mercy Family Health Partners (CMFHP) has an automatic call distribution system (ACD) to monitor and track our telephone statistics. Children's Mercy Family Health Partners

measures on a daily basis and aggregates to a monthly basis telephone statistics for call abandonment rate and average speed of answer (ASA) rate.

Average Speed of Answer

CMFHP's goal is that the calls will be answered in 30 seconds or less.

Total calls monitored per quarter Fiscal Year 2007			
1st Q (7/1-9/30/06)	2nd Q (10/1-12/31/06)	3rd Q (1/1-3/31/07)	4th Q (4/1-6/30/07)
12,736	14,463	17,970	16,442
Average speed of answer per quarter Fiscal Year 2007			
7.39 seconds	10.06 seconds	26.5 seconds	12.67 seconds

Total calls monitored per quarter Fiscal Year 2008			
1st Q (7/1-9/30/07)	2nd Q (10/1-12/31/07)	3rd Q (1/1-3/31/08)	4th Q (4/1-6/30/08)
17,968	16,184	17,836	15,853
Average speed of answer per quarter Fiscal Year 2008			
12.3 seconds	11 seconds	8.3 seconds	8 seconds

Call Abandonment Rate
CMFHP's goal is no more than 5% of calls will be abandoned.

Total Calls abandoned per quarter Fiscal Year 2007 and abandonment percentage			
1st Q (7/1-9/30/06)	2nd Q (10/1-12/31/06)	3rd Q (1/1-3/31/07)	4th Q (4/1-6/30/07)
399 / 3.19%	378 / 3.82%	463 / 7%	236 / 4%
Total calls abandoned per quarter Fiscal Year 2008 and abandonment percentage			
1st Q (7/1-9/30/07)	2nd Q (10/1-12/31/07)	3rd Q (1/1-3/31/08	4th Q (4/1-6/30/08)
901 / 4%	600 / 3%	691 / 3%	432 / 2%

CMFHP has been consistent in meeting goals for calls abandoned as well as average speed of answer. In January 2007, CMFHP implemented a new telephone system. This system allows us to more efficiently answer, monitor and route calls from members and providers and provide improved quality control. Because of the transition and the training required on this new telephone system, CMFHP experienced a slight increase in abandonment rate during the reported period Q3 of Fiscal Year 2007, which kept us from making our goal in the 3rd reporting quarter 2007 above.

CMFHP also experienced a higher call volume in Fiscal Year 2008. In Fiscal Year 2008, even with an increase in call volume, all phone statistics were met consistently for the 12 month period.

Also in 2007, we improved the customer service call documentation system process to become more automated and increase flexibility and detail in documentation, creating better follow-up and communication in each department.

Non-Routine Needs Appointments
Access to Emergent and Urgent Care
Children's Mercy Family Health Partners' policy addresses non-routine appointment needs as follows:

- Routine Care, without symptoms – within 30 days from the time the enrollee contacts the provider
- Routine Care, with symptoms – within 5 business days from the time the enrollee contacts the provider
- Urgent Care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by 354.600, RSMo – within twenty-four hours from the time the enrollee contacts the provider
- Emergency Care – a provider shall be available twenty four hours per day, seven days per week
- Obstetrical Care – within 1 week for enrollees in the first or second trimester of pregnancy; within three days for enrollees in the third trimester

During 2007, Children's Mercy Family Health Partners, as part of the re-credentialing process, routinely reviewed each office's procedures for scheduling appointments. During the review process, no deficiencies were noted. In addition, our Provider Administrative Manual outlines the appointment standards. Finally, through our Customer Service department, no significant issues were noted with respect to members being unable to access the participating provider network for non-routine appointments.

Routine Needs Appointments
Children's Mercy Family Health Partners informs and monitors participating providers' compliance on the guidelines for routine appointments. This is completed through the re-credentialing process, as well as by the Customer Service department, the member grievance system, and the provider complaint, grievance, and appeal processes. During 2007, there were no significant issues identified with members being able to access providers for routine appointment needs.

In general, the Children's Mercy Family Health Partners' network of providers is compliant with the access standards for being able to deliver care to our members on a timely and consistent basis.

Network Adequacy – Provider/Enrollee Ratios

Children's Mercy Family Health Partners (CMFHP) filed its network composition with the State of Missouri Department of Insurance, as required in RSMo 354.603 and 20 CSR 400-7.095, by March 1, 2008. The State reviewed the CMFHP network and provided results indicating that the Children's Mercy Family Health Partners network was in compliance with the regulations to provide adequate access to care.

Specifically, the overall results were:

Primary Care Physicians	100% overall compliance
Specialists	99% overall compliance
Facilities	97% overall compliance
Ancillary Services	97% overall compliance
Overall	98%

Compliance with the above categories by the Western Region counties was:

County	PCP Rate of Compliance	Specialist Rate of Compliance	Facilities Rate of Compliance	Ancillary Services Rate of Compliance	Overall Network Compliance
Bates	100%	100%	100%	100%	100%
Cass	100%	100%	100%	100%	100%
Cedar	100%	99%	96%	100%	99%
Clay	100%	100%	100%	100%	100%
Henry	100%	96%	100%	100%	99%
Jackson	100%	99%	100%	100%	100%
Johnson	100%	100%	100%	100%	100%
Lafayette	100%	100%	100%	100%	100%
Platte	100%	100%	100%	100%	100%
Polk	100%	82%	80%	80%	86%
Ray	100%	100%	100%	100%	100%
St. Clair	100%	100%	100%	100%	100%
Vernon	100%	100%	100%	80%	95%

24 Hour Access/After Hours Availability

On an annual basis, Children's Mercy Family Health Partners Provider Relations department conducts a telephonic survey to determine how our Primary Care Provider offices handle their availability after normal business hours. Calls were placed after the routine 5 pm office closing time and in the morning from 6 am – 8 am prior to office opening. We looked for the following:

- Was the phone answered, and if so, how
  - Answering Machine
  - Answering Service
  - Office personnel or provider

- Number of rings to answer
- Emergency information given
- Pager or personal number given
- Nurse Line information given

All of our contracted Missouri Primary Care offices were surveyed, all provided adequate after hour availability twenty-four hours a day/7 days per week.

The majority of offices have an answering machine which directed the patient to call "911" if this was a life threatening emergency and if not, a pager number was provided to contact the provider on call or a "nurse advice" line number was given to contact a nurse on call. In addition, some offices had an answering service which paged the physician on call.

CMFHP continuously monitors member access to primary care providers by monitoring customer service complaints, as well as monitoring member grievances related to access. During July 1, 2007 through June 30, 2008, there were no significant issues identified with members access to providers.

Open/Closed Panels
Children's Mercy Family Health Partners tracks open/closed provider panels monthly. However, since State enrollment and eligibility is performed on a daily basis, CMFHP recognizes the need to ensure that the data is current when members are selecting a Primary Care Provider (PCP).

During July 1, 2007 to June 30, 2008, CMFHP had a total of 465 PCPs. Of those providers, 76 had a closed provider panel (12 of which are pediatricians, 51 family practice and 13 internal medicine) for a rate of 16% or an open panel rate of 84%. CMFHP did not meet the internal goal of an average of at least an 85% open panel rate for this time period. However, since our membership is over 80% pediatrics and the majority of our pediatricians have open panels we believe our members have adequate access to primary care providers, even though we have been unable to attain our overall goal of 85% of providers with open panels.

The provider relations staff at CMFHP continues to work with providers to keep as many of their practices open to members, as well as look for opportunities to recruit additional primary care providers into the CMFHP network.

CMFHP also tracks member inquiries related to PCP closed panel issues. During this time period, CMFHP documented three hundred seventy nine calls related to a closed panel issue. The number may reflect limited access to a directory at enrollment and printed provider directory inaccuracies.

CMFHP customer service representatives have access to the provider data base, which contains the most current information relating to provider panel status. This enables them to provide timely and accurate information to our members concerning provider status.

Cultural Competency

Children's Mercy Family Health Partners has initiated innovative outreach that – in cooperation with stakeholders and local public health agencies – is reaching all cultural populations within the Western region.

With more cultural populations moving into the Kansas City area, education was needed on differing cultural beliefs and practices as they relate to health care. This education would help increase awareness and understanding of local cultural populations and ultimately help reduce the number of potential health care disparities within CMFHP membership and throughout the Western region.

A close look at Kansas City area demographics compiled during the 2000 U.S. Census revealed an increase in the number and the diversity of cultural populations. In 2000, nineteen cultural populations were represented in the Kansas City area by at least 500 individuals. Continued presence in the local public health agencies confirmed this increase.

CMFHP staff and provider network needed increased awareness and understanding of cultural populations present within our membership.

Effective communication of CMFHP services was necessary for all families in the area (including current members), regardless of background.

CMFHP identified the following interventions as a way to address the above findings and to ultimately reduce the possibility of racial and ethnic health care delivery disparities:

- In 2006, we utilized the services of two full-time bilingual Community Relations representatives to better educate the Spanish speaking community within the Western region about CMFHP services. In 2007, we still have the two full-time bilingual Community Relations representatives as well as 5 full-time Customer Service representatives to assist with members' calls.

- Continued use of communication mechanisms and materials to explain MO HealthNet managed care and CMFHP services. The materials are disseminated to families relocated to the Western region who visit local public health agencies.

- Continued use of the Cultural Awareness Guide and a local resource guide used by staff and our provider network and community organizations.

- Communication materials on CMFHP services were distributed at local public health agencies to immigrant families arriving in the Western Region.

- Communication mechanisms and materials were made available for all members, regardless of background or physical condition, including but not limited to:

    ~ Propio Language Line for members with limited English proficiency
    ~ Member handbook and other member materials in Spanish language
    ~ TTY/TDD services for hearing impaired members
    ~ Member materials in alternative formats (including software) for visually impaired members upon request.
    ~ Bilingual member newsletters

- Held Diversity training in conjunction with Children's Mercy Hospital to educate our staff on dealing with diversity within our organization.

- Educated staff and providers using the Cross-Cultural Health Care Resource Guide that contains topics such as:

  ~ Background and history of each culture
  ~ Health beliefs and practices
  ~ Communication style
  ~ Religion
  ~ Languages spoken
  ~ Family structure
  ~ Food practices/diet
  ~ Children's issues

Through our outreach efforts at local public health agencies and other outreach locations, we reached a vast number of cultural backgrounds with information on MO HealthNet managed care and Children's Mercy Family Health Partners. We will continue our outreach efforts and make communication materials available regardless of background.

The Cross-Cultural Health Resource Guide has been a valuable education tool for both staff and providers and has encouraged culturally sensitive health care. We have distributed more than 10,000 guides and continue to receive additional requests throughout the health care community. The MO HealthNet Division requested permission to use the guide as a reference and benchmark for other plans developing similar tools in 2006.

Requests to Change Practitioners
Children's Mercy Family Health Partners (CMFHP) allows members to change primary care physicians (PCP) at any time. CMFHP does monitor members who change PCPs more than five (5) times to ensure that members aren't abusing benefits or services; however it has discovered limited abusive practices from this report.

Harmony Health Plan of Missouri

Average Speed of Answer
Call Abandonment Rate
Requests to Change Practitioners
Harmony's Member Service department posted solid results for both the Average Speed of Answer (ASA) and Call Abandon Rate metrics for the first two years in the MO Health Net program. In the 2006-2007 contract year, the ASA was 11 seconds and the call abandonment rate was 1.5%. In the 2007-2008 contract year, the ASA and call abandonment rate increased slightly, however the results were satisfactory. The call volume, ASA and call abandon rate totals are shown below.

MO Medicaid-Member	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	2006-2007 Total
Accepted Calls	450	604	423	590	514	553	787	600	547	616	606	555	6845
Answered Calls	443	589	415	587	508	545	778	595	539	605	591	548	6743
Abandoned Calls	7	15	8	3	6	8	9	5	8	11	15	7	102
Average Speed of Answer	9	13	14	8	9	13	10	12	11	11	11	13	11
Abandoned Call Rate	1.6%	2.5%	1.9%	0.5%	1.2%	1.4%	1.1%	0.8%	1.5%	1.8%	2.5%	1.3%	1.5%

MO Medicaid-Member	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	2007-2008 Totals
Accepted Calls	595	643	626	769	877	984	1684	1367	1302	1256	1143	1090	12336
Answered Calls	585	631	613	761	850	966	1660	1340	1280	1207	1110	1072	12075
Abandoned Calls	10	12	13	8	27	18	24	27	22	49	33	18	261
Average Speed of Answer	14	14	15	15	18	17	15	15	14	24	21	21	17
Abandoned Call Rate	1.7%	1.9%	2.1%	1.0%	3.1%	1.8%	1.4%	2.0%	1.7%	3.9%	2.9%	1.7%	2.1%

Requests to change a Primary Care Provider increased in volume comparing the last two years. This was expected due to increased membership. However, changes per 1000 members decreased 18.2% comparing 2007-2008 to 2007-2007.

MO Medicaid-Member	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	2006-2007 Total
PCP Change Requests	47	82	60	89	90	106	143	97	105	131	113	129	1192
Changes per 1k Members	28.7	41.4	23.6	29.6	26.6	28.3	35.6	21.6	22.1	26.5	21.7	23.0	26.3

MO Medicaid-Member	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	2007-2008 Totals
PCP Change Requests	136	154	167	217	153	163	240	205	205	218	210	207	2275
Changes per 1k Members	22.8	24.1	24.1	28.6	18.9	19.4	26.6	19.8	19.5	20.7	19.0	18.6	21.5

Non-Routine Needs Appointments
Routine Needs Appointments
24 Hour Access/After Hours Availability
Timely Access Report

COMPANY:	Harmony Health Plan of Missouri (Missouri Medicaid)
REGION(S):	All

AUDIT INTERVAL:	Annual (2007 only)	
AUDIT REPORTING PERIOD:	2007 Final Reporting	
LINE OF BUSINESS:	MMD	
AUDIT DATE(S):	June 2008	
	PCP Urgent Sick Care:	</= 24 hrs.
	PCP Sick Care:	</= 5 days
	PCP Routine Well Care:	</= 30 Days
	PED Urgent Sick Care:	</= 24 hrs.
	PED Sick Care:	</= 1 week
APPOINTMENT STANDARDS:	PED Routine Care:	</= 3 weeks
	OBGYN 1st Tri:	</= 7 days
	OBGYN 2nd Tri:	</= 7 days
	OBGYN 3rd Tri:	</= 3 days
	OBGYN High Risk:	</= 3 days
	GYN Only:	</= 30 Days
	Specialist Appt.:	</= 30 Days

Methodology Summary:
- WellCare currently uses The Results Companies, Inc., an outside vendor, to complete the Accessibility and Availability audits.

- Audits were performed annually for 2007, and consisted of two rounds which are defined as follows:
    - Round 1 is also known as the initial round. This is when the audit first commences.
    - Round 2 represents the re-audit of all active providers found to be noncompliant during Round 1.

- The Harmony Health Plan of Missouri (hereinafter "MO HealthNet") population is comprised of physician PCPs, OB/GYNs and Specialists. PCPs are defined as providers with a primary specialty type of Family Practice, Internal Medicine, Pediatrics and General Practice. They must be identified as a PCP provider in Peradigm and have an active contract as a participating provider on the 1st day of the month following the day of the population extract.

- The MO HealthNet OB/GYN population consists of physician OB/GYN providers. They must be identified as "OB/GYN", "OBS" or "GYNE" specialists in Peradigm and have an active contract as a participating provider on the 1st day of the month following the day of the population extract.

- In 2007, a sampling of the Top 10 Specialists was also audited.

Findings:

Quality Standard	Benchmark	Round 1	Round 2	Overall Annual Average
PCP Adult (urgent-sick visit)	24 hours	97.9%	100%	98.3%
PCP Adult (sick visit)	5 days	96.9%	100%	97.4%
PCP Adult (routine visit)	30 days	96.9%	100%	97.4%
PCP Pediatric (urgent-sick visit)	24 hours	100%	100%	100%
PCP Pediatric (sick visit)	1 week	100%	100%	100%
PCP Pediatric (routine visit)	3 weeks	100%	75%	95.2%
GYN Only	30 days	0%	100%	13.3%
1st Trimester	7 days	97.4%	66.7%	93.3%
2nd Trimester	7 days	97.4%	66.7%	93.3%
3rd Trimester	3 days	92.3%	50%	86.7%
High Risk	3 days	0%	100%	13.3%
Specialists	30 Calendar Days	92.6%	100%	92.9%
After-Hours	Various	70.0%	35.7%	66.9%

Analysis of Findings:

- Of the 117 Primary Care Providers (adult) successfully audited over 97% of the providers were in compliance with the urgent care, sick care and routine care availability standards.
- Of the 42 Primary Care Providers (pediatric) successfully audited over 95% of the providers were in compliance with the urgent care, sick care and routine care availability standards.
- Of the 39 OB/GYNs successfully audited over 90% were in compliance with the first and second trimester availability standards, with 86.7% complying with the third trimester availability standards.
- An average of 92.9% of the 98 specialists audited were in compliance with the specialist availability standards.
- An average of 66.9% of the 154 providers audited under the after-hours availability standards were in compliance.

Corrective Action Plan for Non-Compliant Providers:

- WellCare Provider Relations Representatives will make every effort to contact each noncompliant provider to explain the audit results and re-enforce the need to comply with the appointment availability & accessibility standards.
- For any provider found to be out of compliance as a result of the second audit, a written notification will be sent requesting their corrective action plan within 30-days of receipt of our communication.

- Those providers identified as being noncompliant for the second time, and who fail to respond to WellCare's request for a corrective action plan, will be referred to the Missouri Medical Director and the WellCare Provider Relations Director for further contact and additional action.

- Those providers who provide an acceptable corrective action plan, written notification will be sent confirming that sufficient documentation has been provided and their status will then be changed from noncompliant to compliant.

Actions to Improve Process

- Provider Relations is responsible for researching and resolving provider demographic discrepancies such as "no longer with office", "no longer with plan", "wrong number", etc. that result in an incomplete call.
- Provider Relations is responsible for educating providers on their contractual obligation and adherence to availability standards as set forth in the WellCare Provider Manuals.
- Operations Compliance will continue to identify opportunities to streamline the audit process to improve efficiency and accuracy in reporting.

Access to Emergent and Urgent Care

Harmony has a robust hospital network available for emergent care services. Those hospitals not presently contracted with Harmony are available to members in emergency situations. Harmony has also continued to focus on contracting efforts with urgent care centers throughout our region.

Network Adequacy – Provider/Enrollee Ratios
Harmony has established contractual relationships with providers in each of the 14 eastern region counties and St. Louis City. Though the network is sufficient by all requirements put forth by state of MO, Division of Insurance, Harmony continues to identify areas for continued growth based upon the Plan's review of the network under the following metrics:

> a. Eligibles to specialist ratio vs. our target membership to specialist ratio
> b. Distance/drive time showing all-sufficient
> c. Referral patterns of the PCPs

Harmony's current provider/enrollee ratio as of June 30, 2008 is 28 members to every one PCP. This ration was derived from the membership of 10,920 and a PCP network of 386 as of June 30, 2008.

Open/Closed Panels
Harmony has established contractual relationships with providers in each of the fourteen eastern region counties and St. Louis City. Though the network is sufficient by all requirements put forth by state of MO, Division of Insurance, regarding primary care providers and hospitals, Harmony will continue to identify areas for continued growth based upon the Plan's review of the network under the following metrics:

> a. Eligibles to specialist ratio vs. our target membership to specialist ratio
> b. Distance/drive time showing all-sufficient
> c. Referral patterns of the PCPs

Harmony has processes to support monitoring of provider access to members for availability 24 hours a day, 7 days a week. Harmony actively recruits nurse practioners for inclusion in the provider network. Mental health and substance abuse providers, as well as dental, pharmacies, emergent and non-emergent transportation providers meet the standards as put forth by the state of MO, Division of Insurance.

Harmony Heal Plan of Missouri (MMD)	
As of 06/30/08	
Total PCP	386
# of PCP Sites	401
PCP Open Panel	88%
PCP Closed Panel	12%
Total SPEC	1,326

Cultural Competency
WellCare has a Cultural Competency Program that is modeled on the CLAS standards promulgated by HHS's Office of Minority Health. Our program's goals are to meet the unique and diverse needs of all members, ensure that the staff of WellCare and its vendors value diversity within the organization and for its members, and ensure that members with limited English proficiency have their communication needs met. In addition, WellCare is committed to ensuring that our providers fully recognize and care for the culturally diverse needs of the members they serve.

Cultural competency is a key component of WellCare's continuous quality improvement efforts. We expect to realize tangible gains in member satisfaction and health outcomes resulting from the measures set forth in this plan. Both of these aims tie directly to the fundamental mission of our company

The specific objectives of WellCare's Cultural Competency Program are to:

- Identify members that face cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on members' race, ethnicity and primary language spoken;
- Make resources available to meet the language and communication barriers that confront members;
- Ensure providers care for and recognize the culturally diverse needs of the population;
- Ensure WellCare employees and vendors are educated and value the diverse cultural and linguistic differences within WellCare and the populations we serve.

Purpose
The Cultural Competency program aims to ensure that:

- WellCare meets the unique diverse needs of all members in the population.

- The staff of WellCare value diversity within the organization and for the members that the plan serves.

- Members with limited English proficiency have their communication needs met.

- Our provider partners fully recognize and are sensitive to the cultural and linguistic differences of the WellCare members they serve.

Objectives
The objectives of the Cultural Competency program are to:

- Identify members that may have cultural or linguistic barriers for which alternative communication methods are needed.

- Utilize culturally sensitive and appropriate educational materials based on the member's

race, ethnicity and primary language spoken.

- Ensure that resources are available to overcome the language barriers and communication barriers that exist in the member population.

- Make certain that providers care for and recognize the culturally diverse needs of the population.

- Teach staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly.

Plan Components
The main components of WellCare's Cultural Competency program are:

1. Needs Assessment – Activities we conduct to identify the cultural and linguistic needs of the communities and members we serve, as well as health disparities present in the enrolled population and the community at large.

2. Organizational Readiness – Steps WellCare takes to make certain that the health plan has the platforms, systems, and people skills needed to operate in a culturally competent manner.

3. Program Development – The implementation of programs to link WellCare to community resources, to enhance the cultural and linguistic capabilities of our provider partners, and to educate members so that their experience with the health system is more positive and their health outcomes are more favorable.

4. Performance Improvement – Ongoing identification of opportunities to improve the operation of the Cultural Competency program, or to improve health outcomes through new responses to cultural and linguistic needs of members.

HealthCare USA

Average Speed of Answer
Pre-authorization Department
The pre-authorization staff use an automatic call distribution system (ACD) to monitor and track telephone statistics. In FY 2008, abandonment rate and average speed to answer were measured and analyzed.

Pre-Authorization Call Volume

ACD System
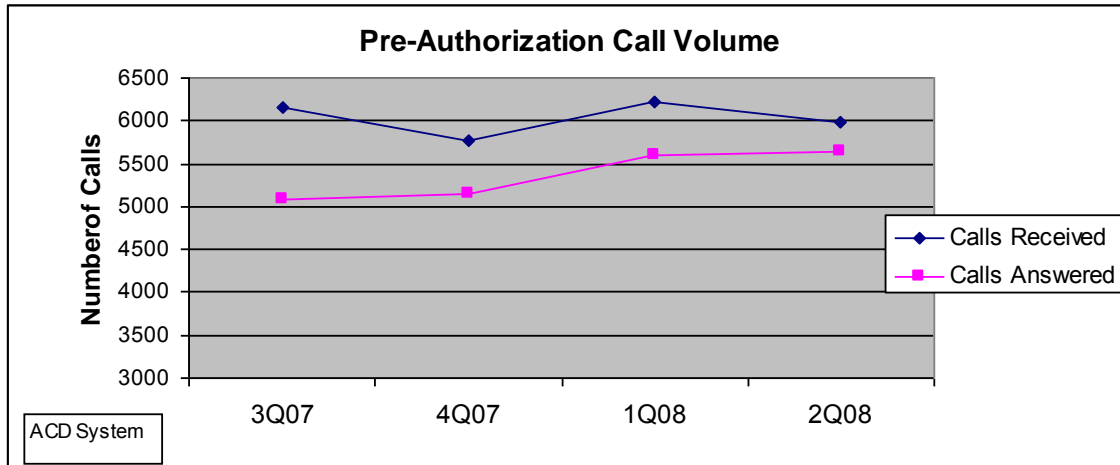
Call volume remained fairly consistent, with an increase seen in first quarter 2008, believed to be related to the county expansion. The volume of calls answered to calls received were more closely aligned in second quarter 2008.

Pre-Authorization Call Abandonment Rate

ACD System
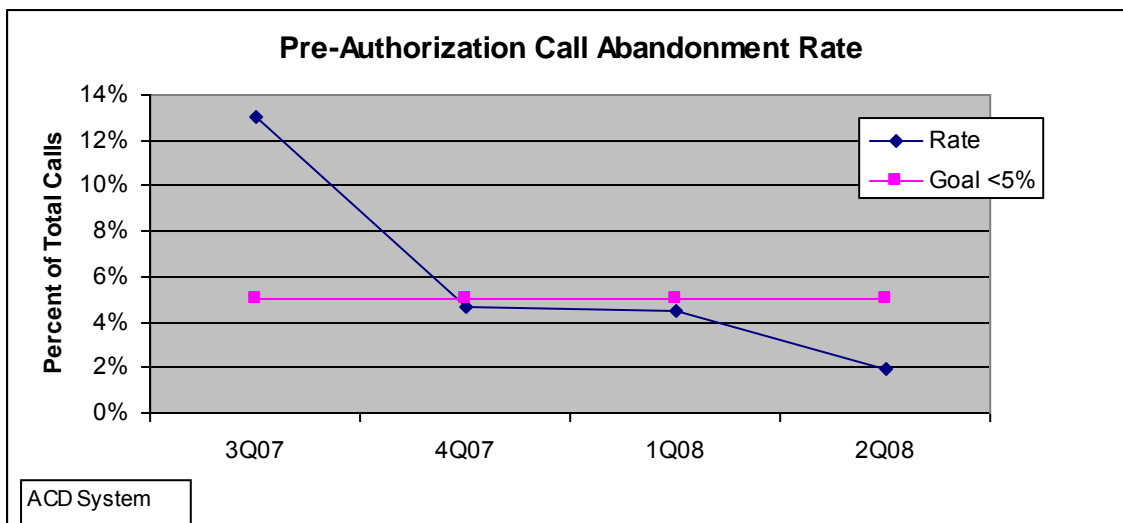
The call abandonment rate was above goal in third quarter 2007 due to a change in staffing. The rate improved, achieving the goal rate of <5% by the 4th quarter of 2007 and has remained better than goal to date.

Pre-Authorization Average Speed To Answer
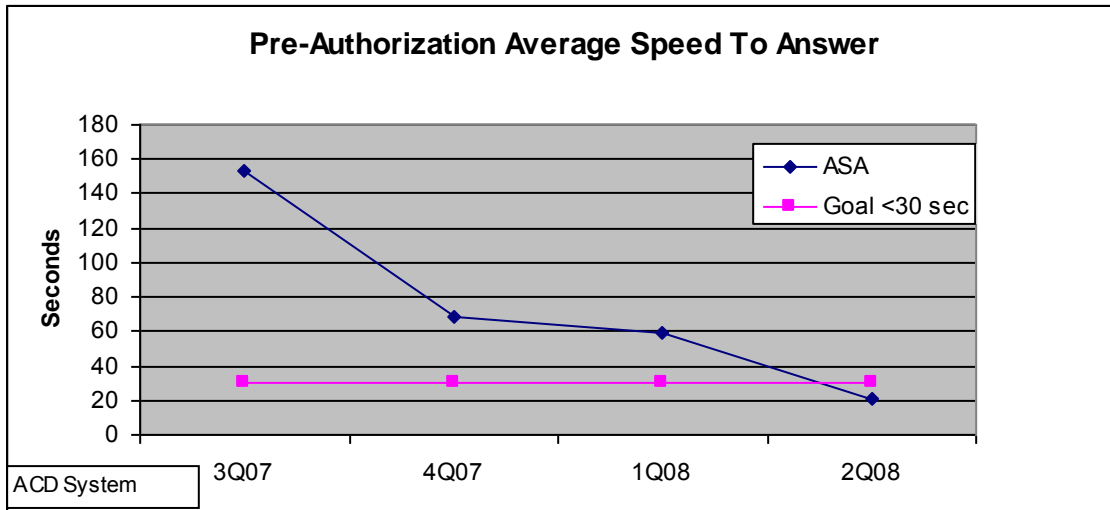
In third quarter 2007 the average speed to answer was above the goal of 30 seconds due to staffing turnover and changes. The rate decreased and met goal during second quarter 2008 after hiring and completing training for new staff.
Customer Service Organization

The Customer Service Organization (CSO) at HealthCare USA continued to focus in 2007 and 2008 on ensuring high - quality customer service as evidenced by ongoing measurement and review of key call process and outcome metrics. Throughout FY 2008, the CSO monitored call volume, call processing indicators, average speed to answer, abandonment rate, and call accuracy.

Customer Service Operations Call Volume
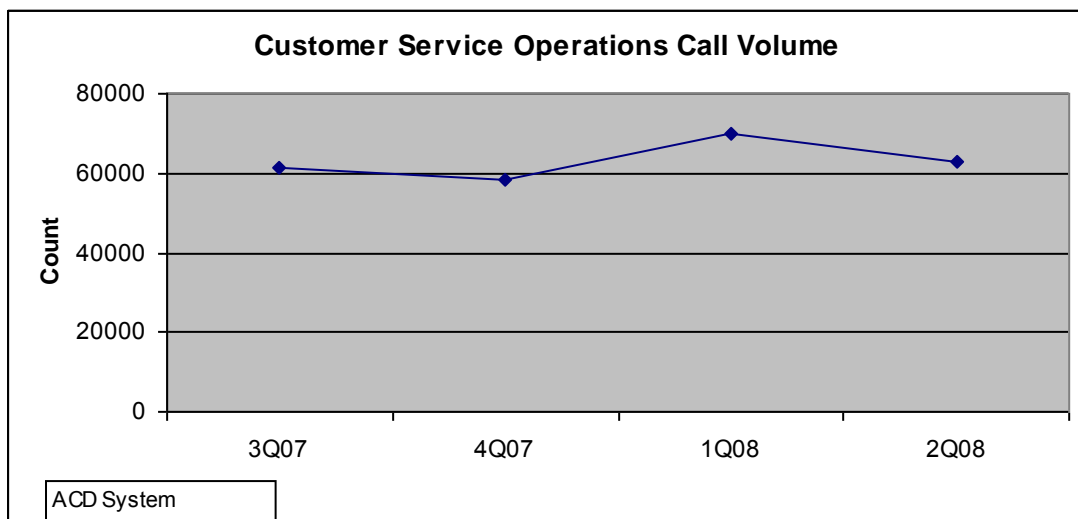
The call volume increased in the first quarter 2008, attributed to an increase in membership because of the county expansion. There was also an increase due to the start of a sticker pilot program. The program tested a sticker on the member identification card that encouraged new members to call the CSO and update their demographic information. .

Customer Service Operations Average Speed to Answer
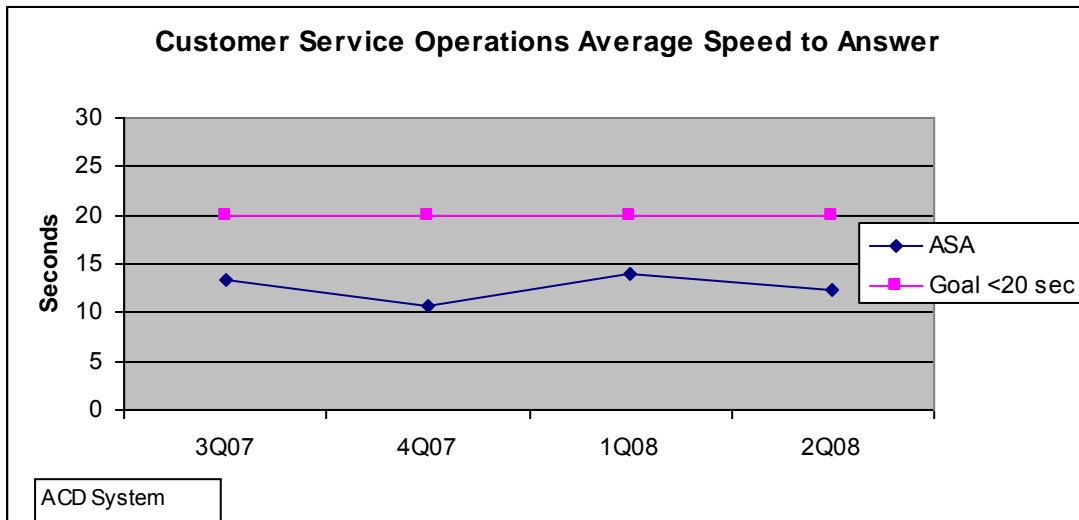
Despite an increase in call volume, the average speed to answer has remained better than the goal of 20 to 30 seconds.

Customer Service Operations Call Abandonment Rate
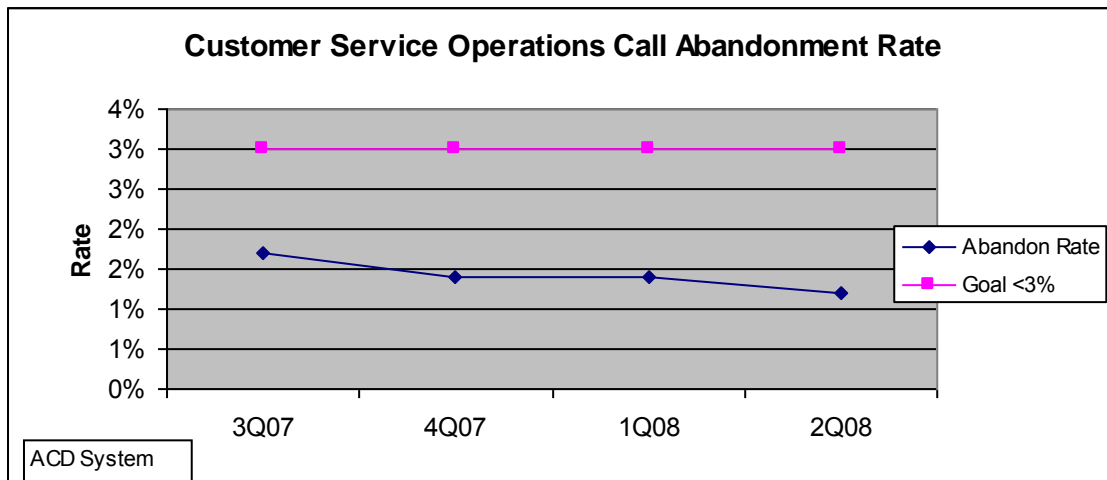
Call Abandonment Rate
The call abandonment rate remained consistent in exceeding the performance goal. The CSO holds bi-weekly team meeting with all staff members to review all policies and procedures on a continuous basis and to assess and resolve any current and potential future barriers to meeting and exceeding key aspects of service.

Customer Service Operations Call Accuracy
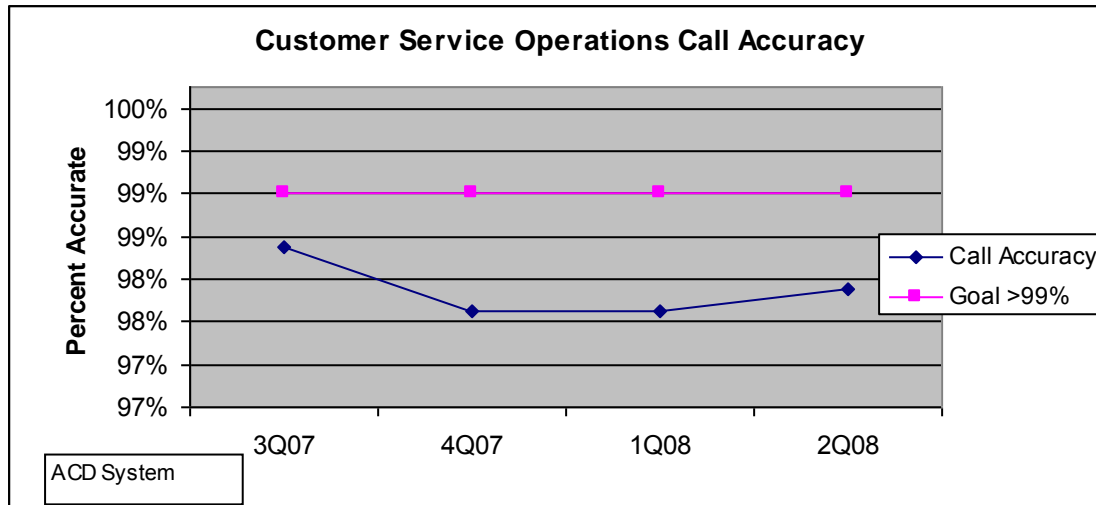
Call accuracy continues to be reviewed and analyzed for improvement opportunities.

Management staff review top provider calls on a monthly, quarterly and yearly basis to identify any trends related to calls, this includes reviewing requests to change PCP. The top four call reasons during FY 2008 are as follows:

- Eligibility
- Claim Status
- PCP Change
- Sticker Pilot Program

The CSO will continue to assess for opportunities for improvement and on-going successes. In FY 2008, the process for ongoing monitoring was improved through the implementation of new web based programs used to monitor member service calls for quality and improved tracking and trending purposes.

Six (6) to eight (8) week training classes are conducted for all new hires that encompasses system overview, benefit review, contract review, provider selection, HIPPA guidelines, navigator review, customer service standards, call tone, documentation, complaints and appeals, member rights, remittance advices, web services, transportation, boys and girls clubs, direct provider and call monitoring procedures. All employees are brought back to training after 90 days to receive additional training on claims processing.

Training programs continue in 2008, with interest in career development of employees, including but not limited to, call tone, documentation, grammar, and outbound call monitoring. A learning management system has been implemented to deliver training for the development of current staff and enhance learning opportunities for staff with visions of growth in the organization.

In 2007, a pilot study was completed to see if attaching a sticker to member ID cards requesting that the participant call member services as soon as they receive the ID card to update demographic information would prompt the member to call HealthCare USA and provide

updated demographic data. A total of 50,000 cards with stickers were distributed at the onset. Outcomes of the pilot study (shown in the table below) indicate success of the pilot. There was a 13.7% response rate from the card and 3% of all the stickers or 23% of all callers made an update to demographic data.

Results of ID Sticker Card Pilot Focus Study

	Cards Mailed	Returned Mail	Total Calls Received	Changes Made
Total	50000	2132	6551	1502
Rate		4.3%	13.7%	3%

In 2008 the sticker project has become a permanent part of the new member ID cards. Percent of calls received in response to the sticker continues to be tracked.
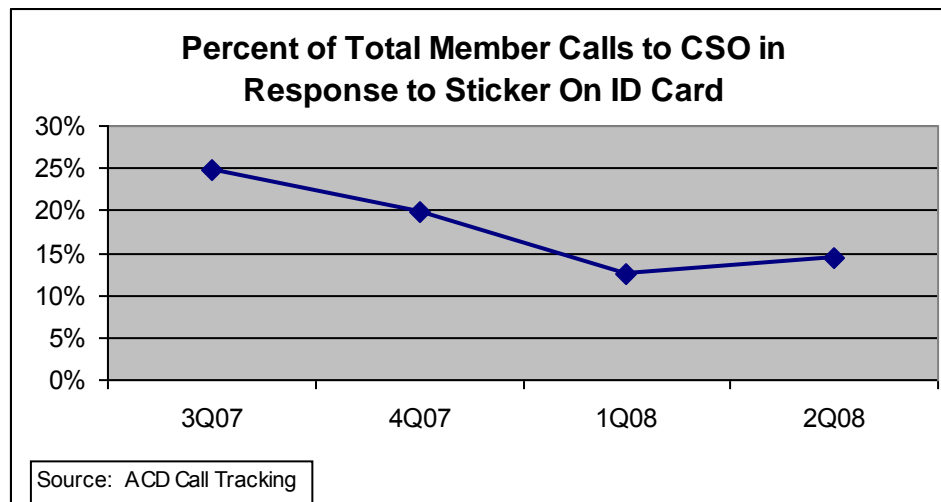
Percent of Total Member Calls to CSO in Response to Sticker On ID Card

Source: ACD Call Tracking

Non-Routine Needs Appointments
Routine Needs Appointments
Access to Emergent and Urgent Care
24 Hour Access/After Hours Availability

2007-2008 Access and Availability Study

The Provider access study included a random sample of primary care providers, OB/GYN providers and high-volume specialists across all three regions of the network. Of all types, 483 network provider practices were represented

Primary Care Providers	296
OB-Gyn Providers	81
High-volume Specialists	106

Source: Access/Availability Study Database

Provider Relations conducted random provider visit and telephonic surveys with providers in all 3 regions to assure access and compliance with contractually required appointment standards, as noted in the Provider Accessibility Standard section of the 2007-2008 Provider Manual. In addition, calls were conducted after-hours to ensure compliance with after hours availability standards.

Provider Access Standards
Appointment Standard - Primary Care
- PCPs will have emergent appointments available immediately.
- PCPs will have urgent, but not life-threatening appointments available the same day.
- PCPs will have routine care, with symptoms, appointments available within 1 week or five (5) business days, whichever is earlier.
- PCPs will have routine care without symptoms appointments within one month.
Appointment Standard – OB/GYN
- OBs will see a first trimester member within seven (7) calendar days of first request.
- OBs will see a second trimester member within seven (7) calendar days of first request.
- OBs will see a third trimester member within three (3) calendar days of first request.
- OBs will see a member identified as "high-risk" within three (3) days or immediately if emergency exists.
Appointment Standard – Specialist
- Specialists will see a member immediately for emergent care.
- Specialists will see a member within 24 hours for an urgent care appointment.
- Specialists will see a member within one week or five (5) business days, whichever is earlier, for routine care, with symptoms, appointments.
- Specialists will see a member within one month for a routine care, without symptoms, appointment.
Provider After-Hours Access Standard
- Participating providers are required to ensure that access to care is provided twenty-four hours per day, seven days per week and to maintain phone line coverage after normal business hours.

Study Results
- Primary Care - Appointment Standards
  o 97% of providers surveyed met these appointment standards
- Primary Care - After Hours Access Standards
  o 95% of providers surveyed met the after hours availability access standard
- OB/Gyn - Appointment Standard
  o 100% of providers surveyed met these appointment standards
- OB/Gyn - After Hours Access Standard:
  o 99% of providers surveyed met the after hours availability access standard
- High-volume Specialist Appointment Standard:
  o 99% of providers surveyed met these appointment standards
- High-volume Specialist After Hours Access Standard:
  o 96% of providers surveyed met the after hours availability access standard

Providers identified in this study as not meeting the required standard for access and availability were contacted by their regional Provider Relations Representative and further educated regarding the standards and the provider's obligation to comply. Demographic updates such as phone number changes, physicians who left the practice, etc. were also identified and corrected.

For the providers identified as not meeting the required after-hours access or coverage, follow-up contacts via Provider Relations revealed errors by provider's office staff such as failure to roll phones over to the after hours phone service, outdated after hours messages or disconnection issues. In each case, the provider responded to feedback from HealthCare USA and corrected the issue immediately.

Following each survey, Provider Relations staff also gave feedback to the randomly selected providers regarding the results of their assessment.

Provider Relations will continue ongoing monitoring of the Primary Care, OB/Gyn and high-volume network providers for appropriate access and availability, and implement interventions as necessary.

Network Adequacy – Provider/Enrollee Ratios
Geo-Access Report
Network adequacy is a key area in performance monitoring for appropriate access to health services for our membership. HealthCare USA reviews and analyzes network adequacy and availability throughout the year and performs a formal geo-access analysis annually. This provides management, contracting, and provider relations necessary information to establish priorities in developing the network and closing any gaps in access that may occur.

Provider Access
HealthCare USA submits an annual Network Adequacy filing to the Missouri Department of Insurance (MDI) for analysis and scoring. For period ending December 31, 2007, HealthCare USA members had 100% access to Primary Care Providers in Central, Eastern and Western regions in Missouri.

Primary Care Providers for Period ending 12/31/07				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	277	676	409	1362
Member to Provider Ratio	67.34	175.22	69.34	113.77
Specialty Care Providers for Period ending 12/31/07				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	404	3245	938	4587
Member to Provider Ratio	46.17	33.26	30.23	33.78
Hospital Providers for Period ending 12/31/07				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	14	34	27	75

Data retrieved from GEO access report results
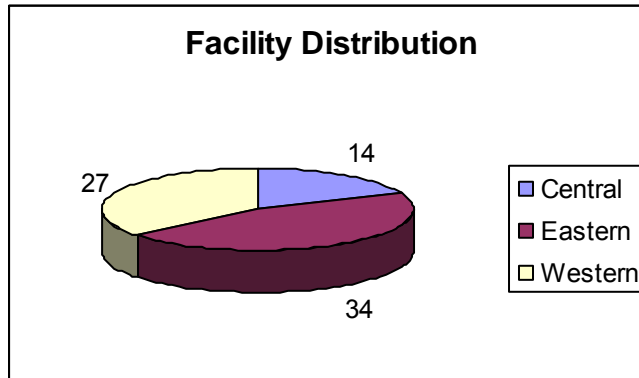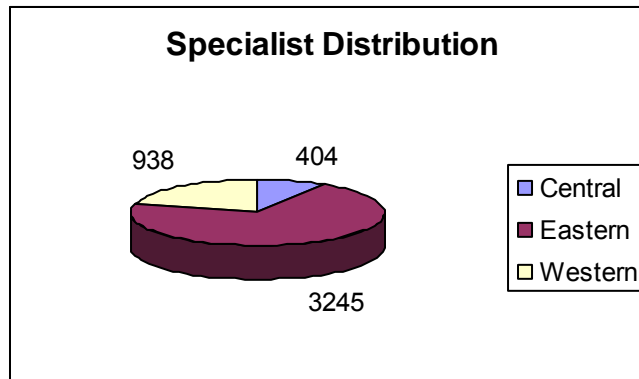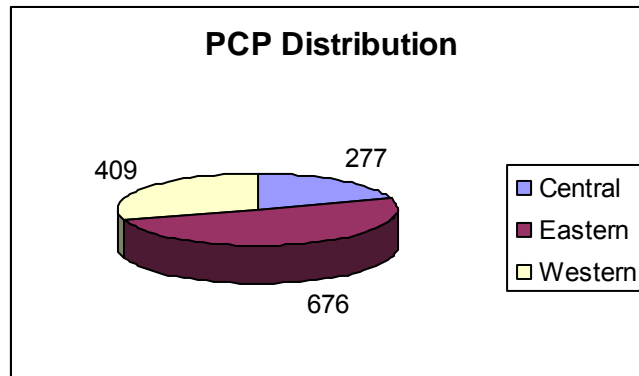
PCP Distribution

409   277

676

- Central
- Eastern
- Western

Specialist Distribution

938   404

3245

- Central
- Eastern
- Western

Facility Distribution

27   14

34

- Central
- Eastern
- Western

Primary Care Providers for Period ending 6/30/08				
Region	Central	Eastern	Western	Total
# Providers	500	709	453	1662
Member to Provider Ratio	55.95	162.44	79.53	107.51

Specialty Care Providers for Period ending 6/30/08				
Region	Central	Eastern	Western	Total
# Providers	902	3287	1008	5197
Member to Provider Ratio	31.01	35.04	35.74	34.48

Hospital Providers for Period ending 6/30/08				
Region	Central	Eastern	Western	Total
# Providers	21	32	34	87

Data retrieved from Geo Access report results

PCP Distribution

453   500   709

Central
Eastern
Western

Specialist Distribution

1008   902   3287

Central
Eastern
Western

Facility Distribution
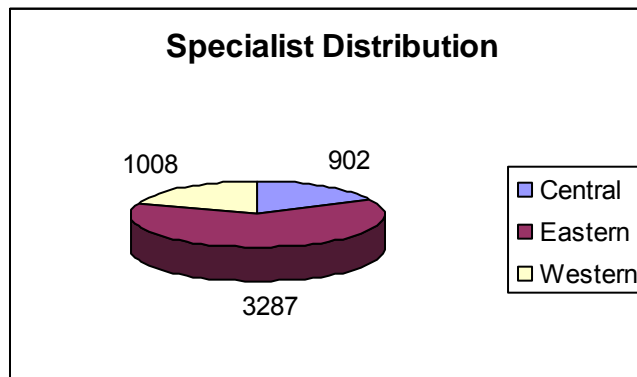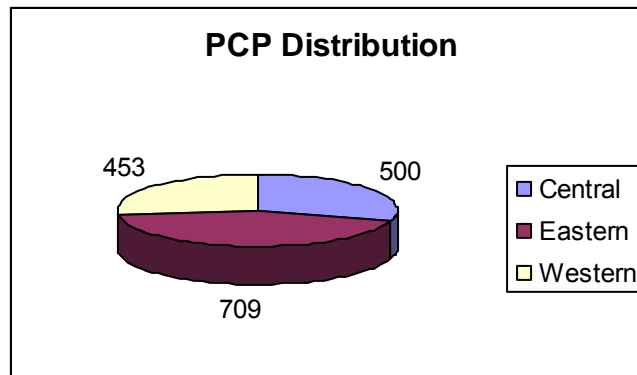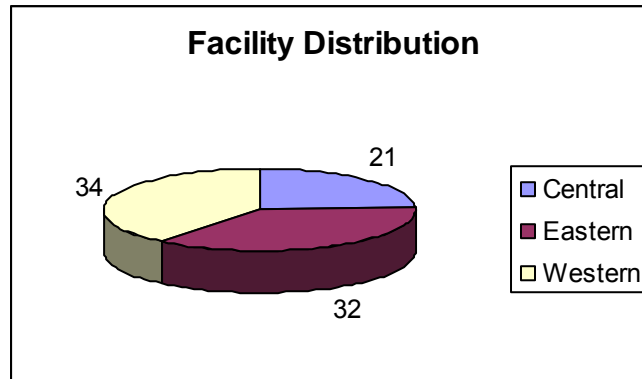
The preceding data represents the distribution of Primary Care Providers, Specialists and Hospitals across the Central, Eastern and Western regions.

HealthCare USA's Network Adequacy data was sent to the Missouri Department of Insurance for scoring and analysis. For period ending December 31, 2007 HealthCare USA received the following scores for network adequacy.

Provider Type	Central Region	Eastern Region	Western Region
Primary Care	100%	100%	100%
Specialists	99%	99%	99%
Facilities	98%	100%	94%
Ancillary	93%	96%	75%
Overall Score	98%	99%	92%

Data retrieved from Geo Access report results

HealthCare USA recognizes that access and availability monitoring is important in ensuring appropriate health care for members and will continue to monitor in 2008 and 2009.

Dental Provider Network

HealthCare USA subcontracts dental services to Doral Dental. Doral and HealthCare USA work collaboratively to ensure appropriate access and availability of dentists across all three regions of the network. Doral and HealthCare USA meet quarterly to discuss key performance indicators, network changes and all other processes as necessary.

Doral Dental's 2007 Geo Access study revealed that 99.9% of members had the desired access to a dental provider, one (1) provider within thirty (30) miles. There were a total of 234 providers at 144 locations across the MO HealthNet regions. Doral actively recruits new dentists to join the network of providers.

Mental Health Network

HealthCare USA subcontracts mental health services to MHNet. MHNet and HealthCare USA work collaboratively to ensure appropriate access and availability of mental health providers across all three regions of the network. MHNet and HealthCare USA meet quarterly to discuss key performance indicators, network changes and all other processes as necessary.

MHNet's final Geo Access study revealed 97.78% of members in Central Missouri had desired access to a mental health provider, 98.64% of members in Eastern Missouri had desired access and 96.02% in Western Missouri had desired access. MHNet continues to actively recruit providers in all three regions to strengthen the provider network.

Open/Closed Panels
In reviewing providers with closed panels in 2007, HealthCare USA had an overall percentage of 26% closed PCP panels. Provider Relations staff contacted providers with closed panels to confirm the reason for the provider's closed panel and to determine if there were any opportunities to open the panel.

- 4% closed to all new patients
- 19% closed to all MO HealthNet patients
- 3% closed to only HealthCare USA patients

Efforts by provider relations to get providers to open their closed panels did not meet with any success in 2007. Provider Relations will continue to monitor the panel status of providers. We will also conduct a review of PCP panel size as part of the PCP panel study for 2008.

Cultural Competency
HealthCare USA provides employee diversity training through the Coventry program entitled Footprints, an online session that educates all employees about respecting the differences of others in the workplace. The presentation consists of a series of slides, case studies and questions that challenge and enhance each participant's understanding of the importance of valuing and respecting coworkers' differences. Certificates are awarded upon completion and participation is tracked.

In 2007 and 2008, HealthCare USA participated in a Coventry-wide workgroup. This group was established in response to the US Dept of Health and Human Services Office of Minority Health's "National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)". The goal of this group is to develop multi-level MCO strategy/program proposal for reducing racial and ethnic disparities in healthcare system. This workgroup developed a proposal for all Coventry plans outlining objectives and initiatives focusing on cultural competence in three areas: members, providers, and employees based on the 14 CLAS standards. In 2008, HealthCare USA has started an interdepartmental workgroup charged with implementing the strategic plan by completing a gap analysis for implementation and knowledge of the CLAS standards throughout HealthCare USA. The team completed an employee survey and has reviewed the results. They have completed workplan to provide member, staff and provider education and to achieve and maintain adherence to all CLAS standards.

MHNet continues to make every effort to keep cultural and linguistic competence integrated into their mission, values and principles, and daily operations. MHNet's provider network represents a diversity of races and ethnicities and languages. In the HealthCare USA network of behavioral health providers the following languages are represented: Arabic, Indian, Bengali, Bulgarian, Chinese, Croatian, Danish, Farsi, French, German, Gujrati, Hebrew, Hindi, Italian, Korean,

Maylayalam, Mandarin, Marathi Persian, Philippine, Polish, Portuguese, Punjabi, Romanian, Russian, Serbo, Sindhi, Spanish, Tagalog, Tamil, Telugu, Thai, Turkish, Ukrainian, and Urdu. MHNet offers lectures, seminars and workshops tailored to address cultural influences and issues related to behavioral health.

Similarly, Doral Dental USA, HealthCare USA's dental vendor, publishes languages spoken by dentists and their office staff in the dental directory. Languages represented are: American Sign Language, Arabic, Bosnian, Chinese, Croatian, Farsi, Filipino, French, German, Hindi, Indian, Italian, Kannada, Korean, Malayalam, Persian, Serbian, Spanish, Talegi, Tamil and Vietnamese.

Requests to Change Practitioners
Requests to change Primary Care Provider (PCP) are tracked by the CSO. These requests are reported and tracked by provider, member, and reason. Quality of Care concerns are investigated and tracked by Quality Improvement staff. Reasons for change are categorized as follows:

Reason For Chance	3Q07	4Q07	1Q08	2Q08
Enrollment/ Access Issue	4464	3522	5738	5227
Provider Request	69	14	5	3
Quality of Care	62	66	35	14
Quality of Service	35	47	13	4
Without Cause	4114	3864	2916	4202
Totals	8744	7513	8707	9450

Source: Navigator

There was in increase in requests to change PCP in first quarter 2008. This is most likely a result of the county expansion and members being auto-assigned a PCP and then changing after enrollment in a plan.

Requests to change are also reviewed for identification of potential fraud and abuse. Frequent member requested changes may be an indication of fraud and abuse. These are tracked to determine the number of PCP change requests made and the reasons for the requests. Cases with frequent changes are investigated and forwarded to the compliance analyst when appropriate.
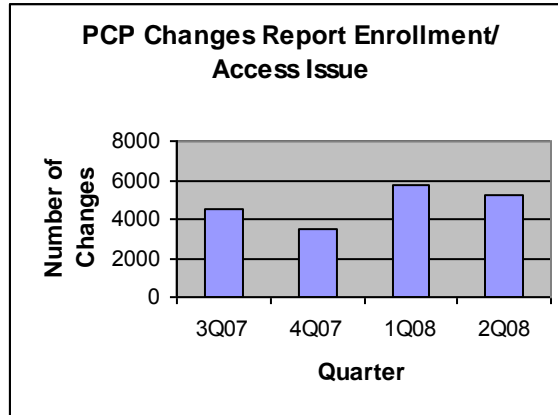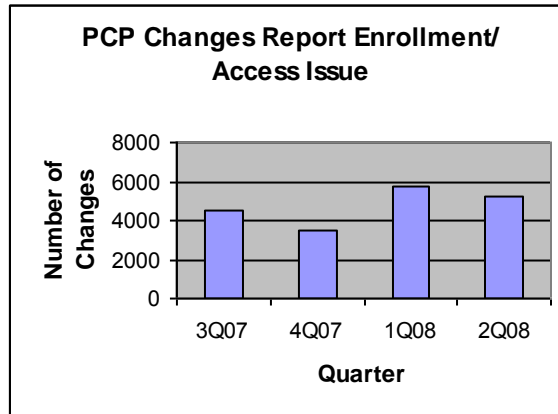
PCP Changes Report Enrollment/ Access Issue

Data Source: Navigator

PCP Changes Report Enrollment/ Access Issue

Source: Navigator

PCP Change Report-Provider Request

Source: Navigator

Total Number of PCP Changes

Source: Navigator

PCP Change Report-Without Cause

Source: Navigator

PCP Change Report-Quality of Service
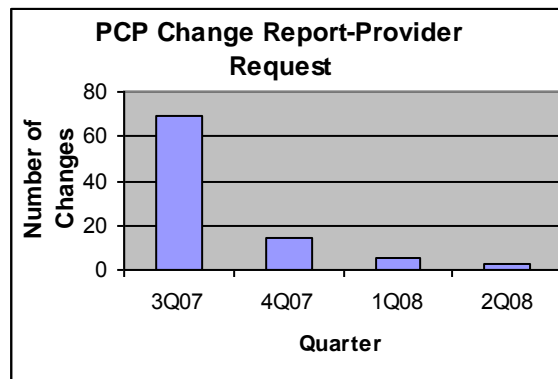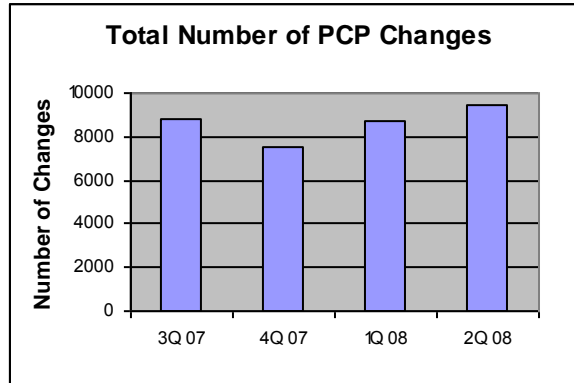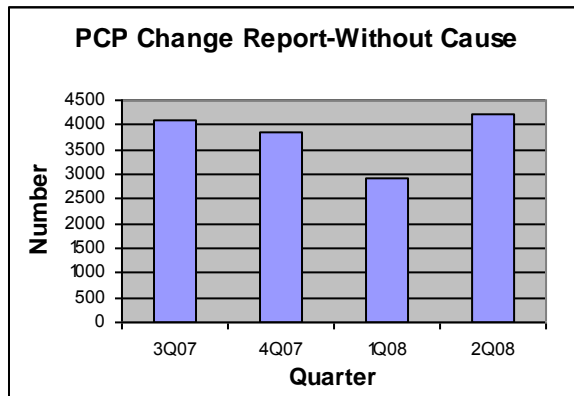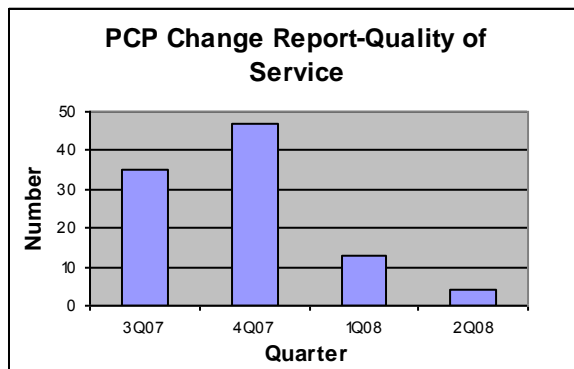
Source: Navigator

Missouri Care

Average Speed of Answer
The average answer times in SFY 08 were as follows:
- Prior Authorization - 11 seconds
- Behavioral Health - 14 seconds
- Member Solutions - 12 seconds

In SFY 08 average answer times were slightly longer than the answer times in SFY 07, and all departments were well below the industry standard of 30 seconds. Missouri Care has dedicated staff committed to delivering the highest level of service.

Call Abandonment Rate
The average abandonment rate during SFY 08 for Prior Authorization, Behavioral Health and Member Solutions Departments, was 2.27 percent, 2.38 percent, and 1.89 percent, respectively. All were well below the industry standard of 5 percent.

Non-Routine, Routine Needs Appointments, and Access to Emergent and Urgent Care
Missouri Care members have a right to the timely provision of health care services. In support of this, Missouri Care adheres to the following appointment availability standards:
- Urgent care, within 24 hours
- Routine care, with symptoms, within 5 business days
- Routine care, without symptoms, within 30 calendar days

Members are informed of these standards in the Missouri Care Member Handbook.
To monitor appointment availability within the provider network, Missouri Care conducts an annual telephonic survey of PCPs. In 2007, a random sample of 153 PCPs was surveyed, and all providers were found to be in compliance with all three standards.

Network Adequacy – Member-Provider Ratios
Missouri Care maintained a very stable provider network, anchored by the University of Missouri Health Care system and its affiliates, within the original 18 counties of the MO HealthNet Managed Care Central Region while also developing a robust new network in the 10 counties added to the Central Region effective January 1, 2008. At the end of 2007, Missouri Care had a provider network consisting of 397 primary care providers (PCPs), 1,482 specialists, and 407 behavioral health professionals. By the end of June 2008, the network had grown to 608 PCPs, 1,893 specialists, and 533 behavioral health professionals. Missouri Care scored 97% overall on our 2008 Network Access Plan submitted to the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP). All specific areas that fell below a 90% score were addressed in a plan of action submitted to and approved by DIFP.

At the end of 2007, the ratio of members per PCP stood at 70:1, while that of members per behavioral health professional was 69:1. By the end of June 2008, the ratio of members per PCP had fallen to 64:1, while that of members per behavioral health professional increased slightly to 73:1.

24-Hour Access/After Hours Availability
As part of the annual appointment availability survey, Missouri Care also monitors the availability of providers after normal business hours. Of the 153 sampled providers, all but two made arrangements for after-hours availability of a health professional. The vast majority utilized answering machines that directed callers to an alternative number providing access to the provider or a covering provider, while some utilized answering services or call forwarding to allow after-hours access to the provider or a covering provider and a few referred members to HealthConnect 24, a contracted 24-hour nurse triage and advice line. The two providers who were found to be out of compliance were contacted by phone during regular business hours and asked to correct the deficiency. Upon re-survey, both had taken satisfactory corrective action.

Open/Closed Panels
Missouri Care monitors the status of PCP panels on a monthly basis. From July through December 2007, the proportion of PCPs with open panels increased from 69% to 78%. By January 2008, the proportion of PCPs with open panels had risen to 86% and remained fairly stable at this level through the end of June 2008.

Cultural Competency
Missouri Care is committed to serving members and addressing any cultural barriers that may present as part of the process. Missouri Care maintains cultural competency initiatives to address specific cultural/language needs that might challenge a member's ability to access care or understand healthy practices that lead to optimum health outcomes. Missouri Care efforts comply with applicable federal and state cultural competency requirements and include:

• Monitoring member demographics to identify the need to provide written materials (e.g., member handbook, mailings, informational communications) in a second language

• Providing members and health care professionals access to interpretive and sign language Services

• Educating plan personnel who have direct contact with members to promote understanding of and respect for cultural differences and develop services to better meet the needs of diverse populations

• Monitoring the practices of network health professionals and providers as they relate to treatment of a culturally and linguistically diverse membership

Missouri Care promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The following items were addressed in SFY 08:
  • Followed phone procedures to use the AT&T phone line for any member who requires translation services. In addition, members were able to call using TTY.
  • Assessment of the number of members by primary language spoken (see Languages Identified, for details).
  • Translated (or made available) materials in Spanish on the following topics:

- Member Handbook
- "Your Pregnancy" Booklet
- "You and Your Baby" Booklet
- EPSDT Reminder Postcards
- Lead prevention/education materials
- Provided mandatory staff training on cultural competency
- Made interpreter services available when members called HealthConnect 24-hour nurse advice line.

Requests to Change Practitioners

Missouri Care members have the right to change their primary care provider two times a year without cause. During SFY 08, there were a total of 33,276 PCP changes. Of these changes, 25,832 were the result of the University of Missouri providers' change in their "pay to" affiliation; 6,064 requested to change to a familiar provider; and 380 changed as a result of a location change of the member or provider. These numbers are up from previous years due to the University of Missouri providers' change in their "pay to" affiliation, as well as a change in the configuration of the provider set up based on corporate standards, and the addition of new members in the ten expansion counties.

Molina Healthcare of Missouri

Average Speed of Answer

MHMO's Average Speed of Answer is reflected in the data below. The goal is 90% of calls will be answered within 30 seconds. Medical Management will attempt to meet the goal in the next fiscal year.

Medical Management Authorization and Referral Calls

ASA	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	60%	68%	82%	89%	88%	86%	77%	76%	79%	83%	77%	81%

Member Services

ASA	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	92%	92%	91%	92%	81%	95%	78%	90%	95%	98%	97%	96%

Call Abandonment Rate

The average goal of <5% of calls abandoned was met as reflected in the data below.

Medical Management Authorization and Referral Calls

Abandonment Rate	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	5.5%	4.9%	2.5%	1.2%	1.8%	1.7%	4.2%	4.6%	2.5%	2.7%	3.40%	2.0%

Member Services

Abandonment Rate	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	2.0%	1.6%	2.3%	1.4%	1.2%	1.4%	4.7%	1.7%	0.79%	0.5%	0.7%	0.6%

Non-Routine Needs Appointments
Practitioners make every effort to see the patient within an average of one hour from his/her scheduled appointment. This includes time spent both in the lobby and in the examination room before being seen by the provider. Providers can be delayed when they incorporate urgent cases, when a serious problem is found, or when a patient has an unknown need that requires more services or more education than was estimated at the time the appointment was made. In addition, members who are late for their appointment may not be able to be seen within the one-hour period. MHMO requires its participating providers to meet contractually required access standards as set forth below:

Medical & Other	
Routine care without symptoms	30 Days
Non-Routine care with symptoms	Within five (5) business days for PCPs
Urgent, non-life threatening care	Within 24 Hours
Emergent (Serious) Medical/Behavioral Health Services	Must be available immediately 24 hours per day, 7 days per week
Mental Health	
Behavioral Health Non-Emergent	5 business days
Behavioral Health Upon PCP's request	Within seventy-two (72) hours
Mental health and substance abuse after care	The lesser of: =<7 days after hospital discharge 1 calendar week; or 5 business days

Routine Needs Appointments
See appointment standards information above.

Access to Emergent and Urgent Care
See appointment standards information above.

Network Adequacy – Provider/Enrollee Ratios
MHMO has developed a geographically accessible network for members throughout the three-region service area. It is of sufficient number, range, and depth to ensure that covered benefits are available to members in a timely manner. MHMO providers include hospitals, physicians, advanced practice nurses, mental health providers, substance abuse providers, pharmacies, dentists, emergent and non-emergent transportation services, emergency medical services, dental health care, and ancillary health care services, etc.

Network Adequacy
MHMO tracks and monitors its provider network adequacy on an on-going basis. Various reporting tools are used to identify areas of improvement. Member inquiries and grievances are monitored by the Provider Services department for trends in network adequacy. In addition, the network is reviewed using the State-required distance standards found in Exhibit A to 20 CSR 400-7.095(1)(E) as a guide. Any known deficiencies are referred to the appropriate Network

Development Manager to proactively recruit targeted providers. Appointment standards and waiting times are also tracked and trended using member inquiries and grievances.

Provider complaints, grievance and appeals are reviewed for any issues relating to provider appointment availability. Provider Service Representatives use their time spent on-site at provider offices to review appointment books and observe the appointment process first hand. MHMO Medical Management Department works closely with both the Network Development and Provider Services Departments to refer and resolve provider-identified issues.

24 Hour Access/After Hours Availability
MHMO maintains a toll-free participant services telephone number. The toll-free participant services telephone including telecommunication service to accommodate deaf participants. MHMO provides twenty-four (24) hours coverage 7 days a week to provide needed authorization of services. The MHMO Nurse Advice Line is a medical triage line available to all MHMO members 24-hours/day, including weekends, and holidays. Members may call the Nurse Advice Line for advice regarding self-care and/or what to do about urgent or emergent medical conditions or situations.

MHMO requires that all participating Primary and Specialty Care Practitioners be available to assist/direct members' needs twenty-four (24) hours a day, seven (7) days a week. Primary and Specialty Care Practitioners should have office hours at least 20 hours per week, preferably over the span of four (4) days per week. An annual phone survey is completed for all primary care providers, OB-GYNs, and other health plan-designated providers. Providers are called after-hours to determine if the provider meets their contractual requirement. Provider Service Representatives visit identified providers who do not appear to meet the standard and review a corrective action plan with the provider and staff. The Provider Service Representative follows up on the corrective action plan to assure adherence.

Additionally, providers are required to complete a form during the credentialing and re-credentialing process to detail their 24-hour access and after hours availability. If a provider's description of access and availability does not meet the access and availability standards, the designated Provider Service Representative will contact the provider to discuss appropriate access.

Open/Closed Panels
PCP's may define the number of members they want to have assigned to their care, or close their panel by submitting written notification to MHMO. Currently, the State of Missouri limits the number of patients per physician to 1,500 patients.

Currently, MHMO has 2,285 participating primary care providers in its network. Of all providers, 95.5% have open panels. This results in a PCP to participant ratio of approximately 1:50. MHMO acknowledges when providers must limit patient panel load due to extenuating circumstances as such conditions could compromise patient care.

Providers may request member removal from the provider's panel for cause, however providers are expected to make every effort to resolve incompatible patient relationships and notify their

Provider Relations Representative prior to making a decision to remove a member from the panel. Reasons for cause include family continuity, abusive behavior, a documented pattern of non-compliance, and failure to keep or cancel scheduled appointments. The provider must notify MHMO in writing indicating reason for the request.

Cultural Competency

MHMO examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MHMO tracks data on the volume of members who have been identified as speaking a language other than English. MHMO's current membership reports reflect a total of 200 or 5% of eligible members that speak Spanish languages as well as English. Incorporated into MHMO's practitioner orientation program is education on processes to access interpreters for members.

MHMO makes available to its members the Relay for Missouri line to assist members that may have hearing impairments or disabilities.

MHMO incorporates cultural competency training into its training opportunities for employees. During a scheduled training day, Merck provided a cultural competency presentation to employees. The Molina Institute for Cultural Competency visited MHMO and presented a cultural update about diverse communities such as the Bosnian community and the Latino community.

Requests to Change Practitioners

Members are allowed to change their PCP up to two (2) times per year after the initial assignment. MHMO considers any request that exceeds the allowed two (2) per year on a case-by-case basis. Consideration is given to issues of provider accessibility, attitude, quality of care, enrollment and acts of insensitivity. In cases where the PCP has left the plan, members must choose or be assigned to a new provider. This is not considered as one of the two (2) times allowed per year. MHMO notifies all affected members in writing at least thirty (30) days in advance of the change, and issues a new member ID card once the member is assigned to a new PCP.

Fraud and Abuse

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Prevention, Detection, Investigation
Blue Cross and Blue Shield of Kansa City (BCBSKC) established the Special Investigations Unit (SIU) in 1986 and it has been in continual operation since that time. The SIU has multiple goals:

- To prevent and deter fraud and abuse through acts committed by providers, members, employees and any other BCBSKC business constituents.

- To deter unnecessary medical services.

- To demonstrate the company's strong commitment to honest and responsible provider and corporate conduct.

- To facilitate compliance with state law, federal law, accreditation agency requirements, contractual requirements, and Blue Cross and Blue Shield Association requirements.

- To prevent processing of fraudulent or abusive claims.

- To facilitate a more accurate view of risk and exposure relating to fraud and abuse.

- To minimize the financial impact of fraud and abuse to BCBSKC and its clients.

- To meet the customer expectations that we will reimburse only for services that are appropriate and do not constitute fraudulent or abusive activity.

We execute this mission through strong inter-departmental processes and communication procedures, supplemented by fraud and abuse detection technology, and supported by appropriate policies and procedures.

Currently, the SIU has three full time staff members. The SIU Manager is a Licensed Practical Nurse. The Fraud Investigator will graduate in October 2008 with a BA in Investigations from Bellevue University. The Clinical Fraud Investigator is a Licensed Chiropractor and holds an accounting degree.

The SIU has other resources available on an as-needed basis, including claims auditors, registered nurses, medical directors, pharmacists, quantitative analysts, IT support personnel, and financial analysts. If required, the SIU has access to external resources such as investigators and independent review organizations for determination of medical necessity and validity of medical records documentation.

The SIU is a department within the Audit Service and Compliance Division (AS&C) under the management of the Director of Audit Services and Compliance Officer. The Director of Audit Services and Compliance Officer reports directly to the President/CEO and has a direct line of reporting to the Board of Directors Audit Committee.

Other activities undertaken by the AS&C Division include:

- Conducting regular reviews and audits of operations to guard against fraud and abuse.

- Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly and that the company's assets are appropriately protected,

- Establishing and maintaining organizational resources to respond to complaints of fraud and abuse.

- Establishing procedures to process fraud and abuse allegations.

- Establishing procedures for mandatory reporting requirements.

- Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.

The SIU currently uses STARSentinel™ software. "STARSentinel is an automated ,early warning' system that applies both standard and user-defined rules to identify billing patterns that differ dramatically from a provider's past history of the norms for a given condition or specialty" (2003 ViPS^{SM}). The software provides a more timely and accurate in-house data mining capability to identify and investigate trends and indicators of fraud and abuse. The STARSentinel software will be upgraded in the 1st Quarter of 2009 to include the pharmacy module. This additional capability will provide the SIU with a more complete view of members and providers. The SIU may receive referrals or identify instances of potential fraud and abuse from any of the following sources:

- Members, providers, other insurers, and the public.

- Personnel in the BCBSKC claims, customer service, medical management, provider services, audit services, underwriting, and any other BCBSKC departments.

- Data studies conducted by BCBSKC and/or contracted external data analysis vendors.

- The BCBSKC Anti-Fraud Hotlines.

- The Code of Business Conduct Hotline.

- The Federal Employee Program (FEP) Anti-Fraud Unit.

- Law and regulatory enforcement agencies such as local police departments, the Missouri Department of Insurance, Financial Institutions & Professional Registration, the Program Integrity Unit, the FBI, or other such agencies.

- The Blue Cross and Blue Association National Anti-Fraud Department (NAFD).

- Federal Anti-Fraud Task Forces.

- Local and/or national media sources.

Employees may report improper activity to their supervisors, the General Counsel, the Director of Audit Services and Compliance Officer, the Deputy Compliance Officer, SIU staff, or a member of the Compliance Committee. In accord with the federal False Claims Act, the Corporate Compliance Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of compliance violations. Employees are allowed to report anonymously.

As a part of the credentialing/recredentialing process, BCBSKC screens providers against the Office of Inspector General (OIG) debarred providers list as well as the Office of Foreign Asset Control (OFAC) anti-terrorist list in compliance with Executive Order 13224. Likewise, BCBSKC screens new and existing employees, members, brokers, and vendors against the OFAC lists and conduct background investigations on all new employees. Certain employees (including those involved in government programs) are subject to repeat background checks at five year intervals.

In general, the coordination or departments throughout the organization, the use of technology, the skills, and abilities of experienced personnel, and the support of executive management combine to provide a comprehensive approach to the prevention, identification, and investigation of fraud and abuse in the BCBSKC service area.

Training and Education
BCBSKC conducts fraud awareness training to highlight the issues of fraud, the red flags that may indicate potential fraud or abuse, and the means to report suspected instances of fraud and abuse. BCBSKC employees are informed about fraud detection and reporting during Code of Business Conduct training and through required compliance training sessions. The Special Investigations Unit will host a Fraud Awareness Day in October for employees of the company. The event will focus on healthcare fraud in general and how each employee can be self monitoring for potential risks of fraud.

BCBSKC notifies providers about issues of fraud and abuse in the Provider Office Guides. As necessary, topics of fraud and abuse will be communicated via provider newsletters and through provider advisory committees.

Children's Mercy Family Health Partners

The Fraud and Abuse Plan requires that fraud and abuse concerns are reported, investigated, resolved and tracked. As part of this process fraud and abuse case data is compiled quarterly with the Compliance Program data and then summarized annually to evaluate the effectiveness of the Program. This information is presented to the Board of Directors. The Chief Executive Officer and the Corporate Compliance Officer provided oversight of the Compliance Program.

Prevention, Detection, Investigation
Children's Mercy Family Health Partner's (CMFHP) Fraud and Abuse Plan outlines specific methods of prevention and detection of suspected, alleged, potential or actual fraud and abuse. Some of the methods used are (1) claims software that identifies anomalies in provider billings or that do not meet the billing payment requirements, 2) delineation of job responsibilities between departments to ensure checks and balances of processes, 3) routine review of member enrollment and dis-enrollment to ensure accuracy of membership data, 4) strong credentialing and re-credentialing processes that evaluate provider's participation in federal and state programs, 5) strong internal processes such as annual employee conflict of interest review, and 6) ongoing training regarding compliance/fraud and abuse identification and reporting.

Tracking Compliance/Fraud and Abuse Cases and Concerns
In 2003, the Compliance department in conjunction with Children's Mercy Hospital's Compliance department developed on-line database programs to enter, track and report compliance and fraud and abuse cases. Children's Mercy Family Health Partners compliance/fraud and abuse database is maintained separately from Children's Mercy Hospital's (CMH) compliance database. Data access and security for the Children's Mercy Family Health Partners database is limited to the CMFHP Compliance Officer, CMH Corporate Compliance Officer and the database administrator. The database is maintained on a secure server. The data from previous compliance/fraud and abuse cases was uploaded in January 2004. The compliance/fraud and abuse database also links the case narratives to the case file. The case narrative is a summary of the case activity once the case is closed. The information on the log would then be used to create the aggregate quarterly and annual compliance/fraud and abuse case reports.

The development of the database has also provided tools for tracking issues that did not meet the compliance/fraud and abuse case file criteria, but are issues that the Compliance Officer feels should be monitored. The compliance database has a monitoring log that is used in these situations. This provides the Compliance Officer with tracking of recurrent issues that may require additional staff training or education or further operational evaluation.

Fraud and Abuse Case Activity
Starting in 2004 with the use of the database, compliance/fraud and abuse case activity is now available through the reporting function of the compliance/fraud and abuse database. The following represents the fraud and abuse case data for Fiscal Year 2008:

- ➢ There were 20 fraud and abuse cases investigated in Fiscal Year 2008, 4 providers and 16 members
- ➢ Of the 20 cases, all were resolved during FY 2008
- ➢ There were 7 CMFHP member cases of fraud and abuse substantiated. All of those cases were referred to DMS in order for it to make lock-in determinations
- ➢ There were 9 CMFHP member cases of alleged fraud and abuse that were investigated but not substantiated
- ➢ There were 2 provider/subcontractor cases of fraud and abuse substantiated.
- ➢ There were 2 provider/subcontractor cases of fraud and abuse that were investigated but not substantiated.
- ➢ All cases were rated as low risk

Training and Education
The database also features a module that can be used to track training and education conducted by the Compliance Officer. This includes annual compliance plan and fraud and abuse plan trainings, employee newsletter articles, provider newsletter articles, etc. The following training and educational activities related to fraud and abuse were completed in 2007:

- ➢ New employee orientation (CMFHP specific orientation provides the employee with basic knowledge and expectations related to fraud and abuse identification, detection and reporting)
- ➢ Annual Education Fair (employees are required to attend an annual education fair or complete the training on line through the Children's Mercy Hospital Online Education System, called CHEX. Both of these venues provide information on fraud and abuse identification, detection and reporting).
- ➢ Annual Corporate Integrity Plan training (CMFHP employees are required to attend the annual Corporate Integrity Plan training, which occurs each January. The training includes review of the Compliance and Fraud and Abuse Plans)
- ➢ Newsletter Articles (employees are required to read the monthly In the Know employee newsletter. Information is routinely submitted from the Compliance department regarding topics related to fraud and abuse).

Harmony Health Plan of Missouri

The Company is committed to comply with applicable federal and state laws, rules and regulations related to fraud, waste and abuse. The Company has created and fully supports a Special Investigation Unit ("SIU"), and has given the primary responsibility to this unit for the detection, prevention, investigation, reporting, correction and deterrence of FWA. The SIU will report to the Chief Compliance Officer ("CCO"), and accordingly, will maintain clear lines of communication with the CCO at all times. The SIU will maintain written policies, procedures, and adhere to standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards. The SIU will maintain effective training and education materials specific to FWA, in support of the overall Company Compliance Program, and will assist in providing training to all employees, business partners, and downstream entities. The SIU will promote the immediate reporting of suspected incidents of FWA by establishing clear lines

of communication with employees, business associates and downstream entities. The SIU will assist in supporting and enforcing established Company compliance standards which are clearly communicated through well-publicized disciplinary guidelines. The SIU will be diligent and alert and will immediately report findings related to potential compliance issues related to internal monitoring and auditing. The SIU will immediately report, as defined by state and federal guidelines, all suspected or confirmed incidents of FWA, and will assist state and federal investigative agencies on FWA investigations upon request.

Responsibilities:
The SIU is responsible for the following:
- Screening all reports of suspected fraud and abuse
- Establishing a file for each case of known or suspected fraud or abuse detected
  Inform the Regional Director of Regulatory Affairs of known or suspected cases of FWA in order to allow for the reporting to the appropriate state and federal agencies
- Obtaining necessary supporting documentation for all case files, including copies of medical records, member applications, correspondence, policies, medical bills and claim forms, corporate records, background reports, and other relevant documents
- Conducting investigations to conclusion in accordance with the procedures established by the SIU
- Maintaining records for a period of not less than ten years
- Educating and correcting providers, institutions, and or business partners on proper billing codes and/or procedures when FWA is identified
- Coordinating with the Legal Department during the course of an investigation as Needed

Investigations consist of performing the extended procedures necessary to determine the occurrence of potential FWA activities as suggested by schemes, indicators, facts, and evidence. The investigative process includes gathering and verifying sufficient information in order to determine whether or not evidence suggests that fraud or abuse may have been committed.

The SIU reports directly to the Chief Compliance Officer, and is one component of the Company's overall Compliance Program. The SIU functions and responsibilities are broken down as follows:

- ❖ Education & Training
- ❖ Prevention and Detection
- ❖ Reporting
- ❖ Investigation
- ❖ Correction, Recovery and Resolution

***Education & Training*:**
Through our Company Compliance Program employees received Compliance and FWA training at time of hire. Noted opportunities in the education and training materials prompted a complete re-work of the program, to include a web based training capability and updated materials. The new education and training program is scheduled for release in November 2009 and we have

included a copy of the materials for your records. All employees are required to attend mandatory fraud, waste and abuse „awareness, prevention and detection' training on an annual basis. The Company will provide a comprehensive anti-fraud education and training course on line, which includes an indepth overview of the impact of fraud and abuse on the health care industry, prevention, and detection techniques and how to report incidents of suspected fraud and abuse.

Other formal and informal education and training course topics may include:
- ❖ Organization and functions of the Special Investigation Unit
- ❖ Anti-fraud policies and procedures.
- ❖ Contract compliance.
- ❖ Fraud awareness, prevention, detection, and reporting.
- ❖ Standards of professional and ethical conduct.
- ❖ Confidentiality of information.
- ❖ Basic auditing and interviewing techniques.
- ❖ Effective use of internal and external investigative resources.
- ❖ "Red Flags" and other fraud and abuse indicators.

Facility, Group, Individual Provider, and Member Anti-Fraud Education and Training
The Company will occasionally publish information in a „Provider Newsletter' featuring articles of interest to facilities, groups, individual providers, and members. Articles written by the SIU and other employees or copied by permission that provide updates, newsworthy topics, and other related information regarding the prevention, detection, and reporting of fraud and abuse will be included in publications. Projected articles may include:

- ❖ Steps to take if fraud or abuse is suspected.
- ❖ Resources available to combat fraud.
- ❖ Transcripts of actual fraud and abuse cases.
- ❖ Statistical reports and surveys illustrating the effects of fraud.
- ❖ Publicity of anti-fraud measures and other deterrents.
- ❖ Federal and State laws.
- ❖ Definition of fraud and elements of proof.
- ❖ Fiscal impact of fraud on business operations.
- ❖ Anti-fraud policies and procedures.
- ❖ The many roles of the SIU.
- ❖ Implications of committing fraud.
- ❖ Contract requirements regarding the fraud, waste and abuse.
- ❖ The effect of fraud the cost of health care
- ❖ Common fraud schemes and indicators.

The company will prominently display posters and other media vehicles which are specifically designed to emphasize the importance of detecting, correcting, and preventing fraud, waste and abuse. These articles will be updated on an as needed basis. Additionally, the Company will post information pertaining to fraud, waste and abuse on the organizations company website, which will include links to referral forms, links to affiliated sites of interest, and links to articles of

interest. The company will also post the Compliance Hotline number, 866-678-8355 on all relevant materials.

Reference Materials
The Company will maintain reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications.

Prevention, Detection, Investigation
Pre-payment Prevention and Detection:
The SIU utilizes an analytical tool called „Payment Optimizer' ("PO"), which is a fraud prevention/detection program developed by the Fair Isaac Corporation. The web based program uses advanced logic and statistical probability to identify potential professional claim lines that warrant further review. These claims lines have passed through all edits and are sitting on the check run tables primed for payment. The claim lines are „scored' each morning, and the results of the review are made available to the SIU. From 07/01/07 to 06/30/08 the SIU reviewed 211 claim lines for MO HealthNet recipients resulting in a net savings of $3934.

On a daily basis, the SIU Fraud Specialists, who are the designated staff responsible for working the pre-payment program, will review the identified claim lines with the goal of determining the validity of the claim. The Fraud Specialists use a combination of claims expertise, Current Procedural Terminology ("CPT") knowledge, International Classification of Disease-Ninth Edition ("ICD-9") knowledge, local and national coverage determinations, member history, provider history, contract language, Correct Coding Initiatives ("CCI") edits, and Company Business Decision Documents ("BDDs") to make the determination of allowing or denying payment.

If after review the examiner does not approve payment, the claim line in question is placed on hold, and will be transferred to our internal claims personnel to make the final decision on denial. This allows the claims personnel the autonomy to override the SIU suggestion. If the claims personnel concur with the decision the claim line is denied and the provider is notified on the check Explanation of Benefits ("EOB") page for the claim. The provider may submit medical records in support of the denied claims, which will prompt clinical and coding review. If the provided documentation supports the previously denied claim line, the Fraud Specialist will reverse the decision and allow payment.

A secondary aspect of the PO tool is the historical data and report capability it provides. This allows the Fraud Specialists to quickly search for aberrant historical billing patterns related directly to the pre-payment activities they are working. Fraud Specialist continually provide the investigative team information on suspect providers which triggers a post pay review.

Post-Pay Data Analysis:
The SIU Data Analytics Team is responsible for creating specialized queries that allow investigators to identify members and providers with suspicious activity or unusual patterns of behavior that can indicate fraudulent or abusive behavior. The SIU utilizes a series of conditional

queries, which were developed by the SIU Data Analytics staff, through Statistical Analysis Software ("SAS"), and run against our main data repository.

They include but are not limited to the following: „Up-coding', „Under-utilization', „Unbundling', „Misuse of Modifiers', 'Unusual CPT Codes', „Over-utilization', 'Double Billing', 'Inclusive Evaluation and Management Services Billed Separately within Global Period', „Services Outside Scope of License', „EPSDT Frequency', „Inappropriately Billed Vaccine and Chemotherapy Administration Codes', 'Anesthesiology Units Excessive or Unusually High', „Inpatient Admission and Emergency Room Evaluation and Management Codes Billed Same Day', „Basic Versus Emergent Ambulance Care', 'Prolonged Service Codes Used Inappropriately', „CPT and Diagnosis Codes Mismatch', „Pharmacy Abuse', „Infusion Drug Usage', „Services by Unlicensed Individuals', „Technical and Professional Radiology Billing Abuse', and „Impossible or Unreasonable Time in a Day Based on Excessive Service Counts'.

Once a provider has been identified as an FWA concern, a more detailed set of reports is generated, allowing investigators to view the entire billing and claims history for that provider. To maximize detection, the SIU thoroughly reviews the entire billing history of the provider, and attempts to identify all areas that are unusual or suspicious. This may result in expanded investigations with multiple allegations. The following reports are run on available to investigators through our SAS tool:

- „CPT Report', which is a summary report of the provider's highest paid codes, dollars Descending

- „Diagnosis Code Report', which is a summary report of the diagnosis codes most utilized by the provider, dollars descending

- „Top Paid Days', which is a summary report of the provider's highest paid days, dollars descending

- „Claim Lines Billed', which is a summary report of the numbers of claim lines the provider bills per day

- „Top Member History', which is a summary report of the members that the provider has received the highest compensation for, dollars descending

- „Age Band Report', which is a summary report of the breakdown of dollars paid to the provider by age group, dollars descending

- „Detail History', which is the complete detail of all the provider's billing, and includes all claim detail

Clinical and Coding Review:
Once an investigation has been triggered and medical documentation is reviewed the SIU is able to detect an array of FWA concerns as a result of clinical and coding expertise. The SIU has a

full time Registered Nurse, a full time Coding Auditor, as well as having the full support of the Company Medical Directors. Through chart and patient interviews, clinical expertise and decision making enhance the ability to detect inappropriate treatment plans, unnecessary services, and underutilization of service and misuse of ICD-9 resulting in improper payment. The following are examples of FWA detected during the clinical and coding review: „Services Not Rendered', 'Quality of Care', Medical Necessity', 'Incorrect Diagnosis Codes', 'Improper CPT Selection', 'Services By Unlicensed Individuals', 'Under-utilization', 'Unnecessary and Excessive Labs and Testing', „Diagnosis Related Grouper ("DRG") Manipulation', 'Hospital Caused Illness', and „Hospital Errors Resulting in Additional Surgery'. The SIU has a full time Registered Nurse, as well as having the full support of the Company Medical Directors. Clinical review is imperative to a successful post-pay detection program.

The SIU Coding Auditor works directly with the SIU Clinical Nurse to review medical documentation. This combination is vital in gaining the complete understanding of the care provided to the patient as well as the code submitted on the claim. Findings are escalated to SIU management often resulting in expanded investigations. Additionally, the findings may be communicated to the SIU data team for further analysis.

Internal Referrals:
The SIU receives multiple referrals from employees of the organization. Employees are trained to look for unusual or suspicious activity, and immediately report such activity through the Company Compliance Program. Employees are given multiple options for reporting suspected FWA and are informed of the rights and protections as whistleblowers as specified in the Deficit Reduction Act ("DRA") of 2005, and as part of the State False Claims Acts that resulted from the DRA of 2005.

Indicators employees come across in their daily duties include but are not limited to the following:
- Paper claims with forged or altered signatures, dates, dollar amounts, or other material changes.
- Facilities, groups, and/or individual providers that do not provide an itemized bill identifying diagnosis, procedures, treatment modality, even after numerous requests.
- Facilities, groups, and/or individual providers that continuously postpone a medical record audit or refuse to allow a medical record audit, particularly if the reason given is vague or evasive.
- Medical bills that appear padded or inflated to cover forgiven co-payments or deductibles.
- Medical bills that are submitted on different dates, but each show the same date of service or overlapping dates of service.
- Dates of service in the medical records do not match dates of service on the bill.
- Medical bills list duplicate procedures or unbundled procedures to maximize payment.
- Medical treatments are unrelated to, or inconsistent with, the diagnosis.
- Facilities, groups, and/or individual providers that routinely render medical treatment that is not medically necessary or provides services unrelated to the diagnosis.
- Medical bills that show an unusual number of procedures, length of stay, irregular patterns of consecutive treatment days, or similar indicators.

- Medical and or pharmacy services billed but member calls to say the EOB reflects services that were never received
- Provider has never seen the patient on the dates indicated on the bill nor has no knowledge of the patient
- Facilities, groups, and/or individual providers that provide services to the member and his/her family members on the same date of service or dates of service close to the member's date(s) of service. This is particularly prevalent in mental health claims and chiropractic services.
- Medical bills show treatment on days either before of after the effective dates of eligibility and enrollment
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider share the same address.
- Members with date spans for inpatient stay in two facilities on the same day or series of days
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider share the same Federal Employer Identification, Tax
- Identification Number, DEA Number, Provider Identification Number, or Group
- Identification Number for billing
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider belong to the same professional corporation, subsidiary, or other business entity
- Providers changing patient diagnosis and clinical information after initial authorization request was denied; then resubmitting with new information in second attempt
- Number of prescriptions, or quantity per prescription, or number of refills is unusually large or if the drug is even refillable (narcotics are not refillable).
- Medications prescribed are not directly related to the diagnosis or standards of treatment.
- Location of the pharmacy is geographically different from claimant's residence or work place.
- Prescriptions are phoned into the pharmacy, but the prescribing physician has no record of calling them in.
- Pharmacy dispensed generic medications while brand name medications were billed.

All employees have the following avenues available to report suspected FWA:
- Informing their Supervisor
- Informing Regional Compliance Directors
- Contacting Corporate Compliance directly
- Calling the Compliance Hot-Line at 866-678-8355
- Utilizing the „E'-Hot Line'; http://wellcarelink.wellcare.com/sites/Trust_hotline
- Contacting the Chief Compliance Officer
- Providing written correspondence through Company mail
- Sending an e-mail to the #SIU e-mail address or e-mailing any of the SIU staff
- Calling the SIU staff directly or meeting an investigator and verbally reporting the
- Concern

External Referrals:
The SIU receives multiple referrals through our external contacts. Providers, business partners and downstream entities have several methods to choose from to contact the Company with concerns related to FWA. Information sharing with state and federal agencies, other insurance

companies and professional associations, can be very beneficial. Public information sources such as newspapers, public websites, and television news often have information related to physician arrests, member arrests and Class Action Suits. For Medicare Part D, coordination with the Medicare Drug Integrity Contractor ("MEDIC") as well as the Pharmacy benefit Manager ("PBM") will generate leads for Company investigators to target. As a member of the National Health Care Anti-Fraud Association ("NHCAA"), the Company has access to the information sharing website hosted by the organization which includes input from well over 100 insurance companies and the regular posting of current activities ranging from indictments to convictions on providers nationwide. This warehouse is constantly updated with new schemes, providers, and or institutions that have been identified by investigators from other member companies. By sharing information, companies and agencies are able to see the „whole' picture, thus exposing all aspects of possible exposure to "FWA".

The Company, through delegated vendor relationships, have specialized personnel with oversight of claims, dental, pharmaceutical, vision, behavioral health and other areas.   Many of those vendors have responsibility to detect, prevent, investigate and correct FWA as well. Through oversight of the delegated vendors, the Company is responsible to ensure that FWA activities are carried out with all business partners, vendors and downstream entities. Clear lines of communication are vital for this element of the program.

The following avenues are available for external referral

Calling Customer Service
Calling 866-678-8355
Contacting the Corporate Compliance Department
Contacting the Chief Compliance Officer
Providing written correspondence through US mail
https://www.harmonyhpm.com/fraudabuse/fraudabuse/report
Contacting the Company in any manner

Maintaining the Ability to Prevent, Detect and Adapt:
The SIU will continually adapt to new schemes through continued education and awareness, gains in technological platforms and overall expertise. The SIU will be proactive in attempting to prevent and detect FWA and will work closely with the Chief Compliance Officer, as a component of the Company Compliance Program, in support of meeting or exceeding state and federal guidelines for addressing FWA. Deficiencies and areas of weakness will continually be addressed by SIU leadership with the goal of maintaining a robust and well rounded FWA Program.

Reporting: The SIU is required to immediately report all suspected incidents of FWA to the Regional Director of Regulatory Affairs. Quarterly reports are also submitted which includes all complaints received. Confirmed cases of fraud will immediately be reported to State and Federal Agencies to include HHS-OIG.

Investigation: The SIU is staffed with 12 highly skilled personnel specializing in investigations, medical expertise, data analytics, pre-payment review, claims and CPT coding. Through patient

interviews, review of medical documentation, data analysis and intelligence and information gathering, investigators are able to drive cases to resolution. The Company is committed to full cooperation with State and Federal Agencies and remains a member of the National Health Care Anti-Fraud Association ("NHCAA"). Investigative steps include but not limited to:

Providers:
- Search the HHS-OIG exclusion database
- Search the NHCAA SIRIS database
- Search for public records and leads on the internet
- Utilize Diamond, Sidewinder and Payment Optimizer to collect all internal data
- Document Par/Non Par as well as Cap or Fee for Service
- Document specialty type and verify medical license via state portals
- Verify and document the provider's NPI number
- Verify and document the provider's DEA number
- Verify and document MO HealthNet ID and Medicare ID
- Search public Division of Corporations websites for provider affiliations
- Log WellCare assigned Provider ID#, Vendor#, and Tax ID#
- LRun the Top CPT and Top ICD-9 reports through ACCESS
- Record total monetary exposure for the entire history with the provider

Members:
- Pull all membership data from the Company database to include eligibility data, LOB, addresses and priority notes
- Search for public records and leads on the internet
- Pull member utilization reports for medical and pharmacy

Business Partners, Contractors and Downstream Entities:
- Search the HHS-OIG exclusion database
- Search the NHCAA SIRIS database
- Search for public records and leads on the internet
- Utilize Diamond, Sidewinder and Payment Optimizer to collect all internal data
- Document specialty type and verify medical license via state portals
- Verify and document the provider's NPI number
- Verify and document the provider's DEA number
- Verify and document MO HealthNet ID and Medicare ID
- Search public Division of Corporations websites for affiliations

Correction, Recovery and Resolution: Driven by the Chief Compliance Officer, the Company is vigilant in its pursuit of FWA activity involving its employees, members, providers, business partners, contractors and delegated entities. Results can range from re-education to termination and referral to law enforcement agencies. This may result in application of the Civil Monetary Penalties Law, False Claims Act, Anti-Kickback Statute or debarment of participation in Federal Programs.

Activities/Focus/Objectives:
- Improve on our relationships with State and Federal agencies

- Drive recoveries in institutional and pharmaceutical areas which is a weakness
- Implement renewed FWA training for employees, business partners, and downstream entities with goal of „model' program by 2010
- Adapt to 2009 OIG work plan; Focus on Hospitals, Skilled Nursing, Part D, Encounter Data, Part B Infusion, Renal Treatment, Ambulance and RAPS

HealthCare USA

The fraud and abuse program continued to be a robust program throughout 2007 and the first two quarters of 2008, by maintaining, as well as updating, the previous year's results and changes. HealthCare USA continues activities to prevent, identify, investigate and resolve fraud and abuse committed by members, providers and, if applicable, the health plan.

The Compliance Management Committee, encompassing the fraud and abuse program, continues to meet to review fraud and abuse issues and updates. Coordination, prevention and detection activities and any open cases are discussed during Compliance Management Committee meetings. This committee is a multi-disciplinary and interdepartmental. Feedback about fraud and abuse issues is received from all HealthCare USA departments.

All fraud and abuse policies and procedures documenting the processes of the fraud and abuse program continue to be adhered to and reviewed on an annual basis, at minimum. These policies, as well as all HealthCare USA policies, are maintained on a shared drive where all employees can access them. All employees are notified monthly via an internal newsletter of policies that were reviewed and/or updated during the month. The fraud and abuse plan had very few changes during its annual review. Changes made did not affect the actual processes related to the fraud and abuse program or the compliance with 2.31 of our State contract. The plan was resubmitted thirty (30) days prior to implementation in accordance with 2.1.2.d of our State contract and was approved by the State agency on May 7, 2008.

Prevention, Detection, Investigation
Processes for fraud prevention, detection and investigation continue to evolve throughout the company, as well as with external parties. Processes for obtaining information related to suspected fraud and abuse investigations also continue to improve. Internal departments that are most likely to encounter or detect fraudulent activities related to members include, but are not limited to, Customer Service Operations (CSO), the Pharmacy Department, Case Management, and Provider Relations.

The Special Investigations Unit (SIU) runs reports to detect and investigate potential provider fraud and abuse cases. The SIU administers prospective and retrospective review of medical claims submitted by providers to assess billing patterns. Through analysis of claims data and medical record reviews, the Quality Improvement Department can detect potential fraud and abuse activities perpetrated by either a member or provider. The SIU Department will be implementing new fraud and abuse software in the future. This initiative demonstrates an on-going commitment to improving prevention, detection and investigation.

External parties HealthCare USA works with to investigate, monitor and/or report suspected fraud and abuse activities include, but are not limited to subcontractors, physicians, pharmacists, family members of enrollees, case workers, the State agency and the Office of Inspector General. Individuals who are reported receive education and/or corrective as necessary.

When a referral is received from anyone , an investigation is immediately initiated. The Regulatory Compliance Analyst initiates investigations by receiving all applicable information from the referring party and contacting other parties as necessary, including primary care providers (PCPs), pharmacists, etc. An initial contact is made to suspected members via an initial notification letter to offer assistance. Members are referred to Case Management or other medical management services as indicated.

All cases initially opened due to pharmacy issues are reviewed with the Pharmacy Director to assess and determine next steps. In severe cases when the lock-in program is appropriate, members will be locked in to one provider to obtain all services and/or medications. Cases that deal with mental health/substance abuse are referred to MHNet, HealthCare USA's mental health subcontractor. All open cases are continually monitored. Updates related to open cases are reported to the State at least quarterly until all fraudulent and/or abusive activities cease and the case is closed. As a result of the transient nature of the MO HealthNet population, HealthCare USA maintains an open case for three months after a member opts out of this plan.

The table below shows the number of cases reported throughout the last four (4) quarters:

Quarter	Cases Opened	Cases Closed
Q1 '07	25	12
Q2 '07	13	3
Q3 '08	14	22
Q4 '08	20	2

Source: HealthCare Fraud and Abuse Database

Of all fraud and abuse cases reported, pharmacy continues to have the highest volume. Due to the high volume of cases that relate to pharmacy, all cases, regardless of the reason the case was opened, are reviewed with the pharmacy director quarterly.

The pharmacy lock-in program is maintained for a minimum of twelve (12) months, regardless of whether the member opts out of the plan or not. After twelve (12) months, pharmacy cases are reviewed to evaluate the outcome of the lock-in program and determine if the lock-in process should be extended or not. In cases where the member opted out of the plan for three months or longer, the case is closed.

The outcomes of the Compliance Management Committee, encompassing the Fraud and Abuse Committee, and any updates on the fraud and abuse program, are reported to the State agency and HealthCare USA's QMC and Executive Quality Committee at least annually and recommendations are received from these committees.. .

Assuring timeliness of investigations and accuracy of data collection and reporting continues to be high priority. HealthCare USA continues to assess and improve processes related to fraud and abuse detection and investigations through on-going research and evaluation of new ways to minimize fraudulent and abusive activities and implementation of enhancements to the fraud and abuse program.

Training and Education
HealthCare USA staff received ongoing training and education throughout FY 2008. Mandatory annual training and in-services for all employees includes general health care fraud training. More extensive education is provided throughout the year via the internal employee newsletter, all employee meetings, interdepartmental meetings, wallpaper and bulletin board postings throughout the office. Along with periodically distribution of fraud and abuse education to employees, the Regulatory Compliance Department held a Compliance & Ethics Lunch 'N Learn in June 2008, which included fraud and abuse topics. The Lunch 'N Learn included 99 employees from our St. Louis, Jefferson City and Kansas City offices.

Missouri Care

Missouri Care maintains and implements a Fraud and Abuse Plan. The Fraud and Abuse Plan has been developed to help prevent, detect and report potential incidents of fraud and abuse to appropriate regulatory agencies.

Prevention, Detection and Investigation
Missouri Care personnel or any other party (including Missouri Care members, government agency or the public) can identify and report a potential compliance issue or concern. The identified potential compliance issue or concern is communicated to the Missouri Care compliance officer as a report (hotline call, telephone call, e-mail, written correspondence or other means). The Missouri Care compliance officer logs and documents all compliance issues or concerns that have merit.

In SFY 08 there were 22 fraud and/or abuse issues reported. Each issue can be placed under one of three categories: provider, member or employee.

Provider
Examples of provider fraud and/or abuse include but are not limited to: provider billing for services and supplies not rendered, upcoding and unbundling, level-of-care misrepresentations, false information on claim forms, underutilization, kickbacks for patient/member referrals, illegal self-referrals and lack of appointment availability for members.

There were 20 examples of provider fraud and abuse in SFY 08.

Member

Examples of member fraud and/or abuse include forging prescriptions, using stolen ID card, loaning ID card to others to obtain services and physical, mental, sexual and/or emotional abuse of a member.

There were 2 examples of member fraud and abuse in SFY 08. These incidents included aberrant pharmacy utilization patterns and/or behavior and misuse of member identification card.

Each incident is monitored on an ongoing basis. If a member loses eligibility with Missouri Care, he/she is put on a watch to see if eligibility with the plan is regained. Each case is managed by the manager of Medical Management and case managers to help the member receive the necessary medical services and to help prevent abuse.

Employee
There were no incidents of employee fraud and abuse reported in SFY 08.

Training and Education
Each employee participates in a Missouri Care Health Plan Compliance Program training seminar conducted once per calendar year. Part of this training addresses Fraud and Abuse. Attendance for all employees at this annual Compliance Program training seminar is mandatory. An attendance log is maintained for each training seminar conducted.

Training in SFY 08 included a summary of the types of fraud and abuse that should be reported to the compliance officer. Examples of fraud and abuse were discussed from the previous year and used as training aids.

Molina Healthcare of Missouri

Prevention, Detection, Investigation
MHMO is committed to preventing, detecting, investigating, and reporting suspected fraud and abuse activities by providers, subcontractors and members. MHMO monitors provider fraud for underutilization of services and beneficiary/provider fraud for over utilization of services. MHMO may identify provider fraud and abuse by reviewing for a lack of referrals, improper coding (up coding and unbundling), billing for services never rendered or inflating the bills for services and/or goods provided. MHMO may identify beneficiary fraud by reviewing access to services, such as improper prescriptions for controlled substances, inappropriate emergency care or card sharing.

MHMO's fraud and abuse activities include the following:

- Conducting regular reviews and audits of operations to guard against fraud and abuse
- Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly
- Educating employees, network providers, and members about fraud and abuse and how to report it
- Providing effective organizational resources to respond to complaints of fraud and abuse

- Maintaining procedures to process fraud and abuse complaints
- Maintaining procedures for reporting information to the state agency
- Monitoring utilization/service patterns of providers, subcontractors, and members
- Implementing corrective action plans to strengthen internal control of fraud and abuse activity

All suspected fraud and abuse activities, including pharmacy lock-ins, are reported to MHMO's QIC and Quality Improvement sub-committees as appropriate. They are reported to the State agency on a quarterly basis. During FY2008, there were nine (9) cases of suspected fraud and abuse and there were 16 members who were entered into a pharmacy lock-in.

Training and Education
Providers are educated regarding fraud and abuse as part of their orientation. This information is included in the Provider Manual and on the MHMO website. MHMO may provide an article in the provider newsletter regarding the subject of fraud and abuse when appropriate. Members are educated regarding fraud and abuse through the Member Handbook and through the member portal of our website. MHMO employees receive fraud and abuse education during new employee orientation.

Information Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Claims Processing – Timeliness of Claims Payment
BCBSKC administers claims processing via policies and programming according to RSMo 376.383 and RSMo 376.384. FACETS is programmed to process claims in accordance with MO HealthNet requirements. Monitoring is done on a daily basis, measuring inventory levels and quality performance, which ensures claims are being processed correctly and accurately.

The BA+ Unit reports monthly basis to the BA+ Oversight Committee the claims processing timeliness statistics. The statistics are generated by the Operations Performance Improvement Unit within BCBSKC's Operations Division. The BA+ Oversight Committee is managed by the Plan Administrator and Director of State Programs.

New Directions Behavioral Health processes claims through EPOCH, according to these requirements/Statutes. Their timeliness is monitored by Audit Services and reported for oversight to the Delegated Oversight Committee.

	Claims Accuracy (Goal 97%)	Inquiry Accuracy (Goal 97%)	Claims Processed
Jul-07	94.44%	96.70%	26,710
Aug-07	100.00%	95.57%	23,814
Sep-07	96.88%	98.01%	22,311
Oct-07	100.00%	98.10%	32,805
Nov-07	100.00%	98.10%	25,636
Dec-07	100.00%	99.00%	28,636
Jan-08	100.00%	99.36%	27,537
Feb-08	97.92%	100.00%	24,623
Mar-08	96.88%	98.11%	31,932
Apr-08	98.44%	99.10%	28,557
May-08	100.00%	99.08%	26,501
Jun-08	100.00%	98.2%	31,091

Membership
Membership is received nightly from the State of Missouri MO HealthNet Division and uploaded to FACETS. BCBSKC staff use this information to communicate with members. Currently, BA+ has approximately 27,000 members.

Providers

A listing of providers is provided to members at the time of enrollment into BA+. Members may contact BA+ Customer Service and request a copy of the Provider Directory as needed.

In addition, the listing of BA+ providers is located on the BCBSKC web site (bcbskc.com). Provider information is current in the FACETS system.

Changes to the provider network are sent through Infocrossing nightly. The entire file is sent weekly.

Children's Mercy Family Health Partners

Claims Processing – Timeliness of Claims Payment

Children's Mercy Family Health Partners (CMFHP) continues to refine and improve the claims processing system and work flow.

Below are the fiscal year claims processing results.

	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
Processed	29,969	42,550	38.076	48,884	40,162	29,117
Accuracy	*	*	99.92	99.9	99.7	99.1
Days to Pay	8.11	9.52	8.46	7.79	5.81	6.16

	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
Processed	42,515	30,909	33,329	51,119	40,117	34,469
Accuracy	99.7	99.2	99.6	99.65	99.8	99.8
Days to Pay	7.60	9.28	7.12	8.95	7.82	9.26

* Department Quality Review suspended in July and August of 2007.

Children's Mercy Family Health Partners has continued to enhance the quality review process to ensure that the claims data received from providers is accurately and timely processed for payment. This process looks at the scanning and imaging process and validation as well as the accuracy of system pricing tables and processing by each individual claims analyst.

Children's Mercy Family Health Partners uses a coding detection software called Code Review. This software allows for the review of professional claims and instances of unbundling of procedures, as well as services provided during a global surgical period

and the appropriate use of multiple surgical procedures and the accurate payment of those services. This continues to be an ongoing refinement process to ensure that we are correctly interpreting coding conventions.

Highlights of fiscal year 2008 were the implementation of NPI, establishing weekly provider payments in October of 2008, and increasing and training our Claims Analyst staff.

Membership
During 2008, Children's Mercy Family Health Partners (CMFHP) made no changes in how membership data was received from the State and uploaded into our information management system. The Information Technology department continues to work in conjunction with the Customer Service department to ensure that daily data received from the State is readily available in the membership information/eligibility system. In 2007, a full time Eligibility Specialist position was created within the Customer Service department to ensure that the all member eligibility records were updated and maintained accurately. In addition, the newborn enrollment process was automated, making a full-time employee available for customer service calls.

Customer Service staff daily reviews the data received indicating members who did not select a PCP and ensures that a PCP is selected (auto-assigned) to the member so that he/she will receive a member ID card within the specified time frame of five (5) days. In 2007, the CMFHP website was automated, giving members the ability to request Primary Care Provider (PCP) changes via the web site. The PCP assignment process was also improved through the development of a program that would auto-assign members to open panel PCP's without employee intervention. For each PCP assignment, ID cards were generated automatically.

Customer Service also continues to track returned mail and update member addresses and phone numbers in a secondary field to increase the accuracy of mailings and outbound calls to members. The Customer Service staff also communicates with the MO HealthNet Division employees when members are identified with mailing addresses outside of our service area.

Finally, Customer Service requests language preferences from members and updates the language field in the eligibility software as appropriate. Late in 2007, Customer Service also began obtaining member's e-mail addresses to send correspondence such as the member newsletter to e-mail instead of the postal service.

Providers
Children's Mercy Family Health Partners utilizes Cactus software to maintain the credentialing database of providers. The Cactus database allows for the generation of unique provider ID numbers, maintenance of languages spoken by participating providers, licensure information, educational backgrounds including residency information, and office information. In addition, CMFHP is able to produce on a monthly basis, provider directory updates that can be inserted in the Member

Handbook/Provider Directory as well as distributed to Customer Service staff to assist members with provider selection or questions related to the provider network.

Children's Mercy Family Health Partners also maintains provider information in the claims system. With consistent communication between Provider Relations and Data Quality, the provider payment/contract information is kept current and accurate. Our claims payment system contains current Tax ID Numbers, contract arrangements and fee schedules, as well as billing/payment information.

Harmony Health Plan of Missouri

Claims Processing – Timeliness of Claims Payment
The Claims Department is responsible for researching and processing institutional and/or professional claims, customer service and configuration issues.

These activities include:
- Researching and tracking claims issues
- Making final determination of issue/claims resolution
- Coordinating end-to-end resolution of operational related projects or correspondence
- Researching post payment claims issues and take necessary action to resolve
- Working with provider relations team on operational issues
- Processing claims that are pended by making a final determination
- Processing adjustments related to projects or correspondence
- Researching post payment claims issues and take necessary action
-

The Departmental goals are to assist Provider Relations to recognize the provider's specific needs and maintain a mutually respectful relationship. We support and encourage Provider Relations team in their education of providers so that the maximum appropriate reimbursement is obtained.

Data is collected, analyzed and reported, and that health operations are in compliance with state, federal and MO HealthNet Managed Care contractual requirements. Clean claims are paid within
30 days from receipt or incur interest payments in addition to reimbursement.

Reports are generated by the claim processing unit to ensure timeliness of the processing of claims (on a first in/first out basis). In addition, Claim Management reports are generated weekly to monitor claims turn around time. If a "clean" claim from an unaffiliated provider is not paid within thirty (30) days of receipt, WellCare will pay interest and penalties in accordance with the rate that is established under the MO State regulations or statutes.

Interest payments are generated using a proprietary application that accesses WellCare's core claim payment system. Interest payments are calculated monthly using a 3-step process which includes entering the line of business, claim type, and the time period for

which interest is being generated. This application then calculates interest on any claim finalized within the selected time period based on the parameters set forth in the program and creates a batch of checks. The batch of checks and remittance advices are printed and mailed to the provider within 1 business day. The WellCare claim process is designed to take no more than 30 days for all claims. WellCare consistently meets this target.

As indicated in earlier discussions encounter and claims issues continue to challenge the accuracy of Quality data however consultants, subject matter experts and work groups have been formed to create and execute process improvement work plans. The QI program for MO is ongoing, continuous and based upon evaluation of past outcomes.

We verify that we are in compliance with regulatory requirements when dealing with provider complaints in accordance with all applicable rules and regulations, handling and addressing the resolution of any provider complaints

Membership
Providers
Harmony employs the Diamond 950 system as the core transaction processing system for the maintenance of provider, member, benefit, and contract information. This top-tier commercial system supports our core transaction processing functions. Operating on Sun hardware and an Oracle database, Diamond is designed to be scalable to accommodate internal growth and growth from acquisitions. We use our systems for premium billing, claims processing, utilization management, reporting, medical cost trending, planning and analysis. The systems also supports member and provider service functions, including enrollment, member eligibility verification, primary care and specialists physician roster access, claims status inquiries, and referrals an authorizations.

Harmony uses Diamond to adjudicate and pay healthcare claims submitted to the plan by providers on behalf of the eligible beneficiaries. Harmony also uses Diamond to store and record non-financial transactions (so-called "encounters") submitted to the plan as evidence of healthcare services rendered under pre-paid and capitated arrangements. Additionally, Harmony uses Diamond to manage and record authorizations and referrals among the various healthcare providers who deliver health care services on behalf of Harmony's beneficiaries. The Diamond system provides for the storage and maintenance of demographic information about beneficiaries.

Web Enhancements:
Harmony/WellCare has recently launched our updated website which provides a greatly enhanced resource for our members and providers. A variety of easy-to-use tools created to streamline dayto-day administrative tasks for providers and improve resource accessibility for members has been added.

Key Features and Benefits:

Harmony's web site gives providers immediate access to what we understand they need most. All participating providers can leverage the following features:

• Claims Submission Status & Inquiry
- Submit a claim.
- Check the status of a claim.
- Customize and download reports.

• Member Eligibility & Co-pay Information–Searchable member database provides member effective and term dates, plan type, PCP contact and co-pay information.

• Authorization Requests–You may submit authorization requests online, attach clinical documentation and check authorization status. You may also print and/or save copies of authorization forms once received in your online mailbox.

• Pharmacy Service & Utilization– View and download a copy of our preferred drug list, see drug recalls, access pharmacy utilization reports, and obtain information about our pharmacy services.

• Provider News–View and download our latest announcements.

• Your Inbox–A provider-specific inbox where you receive notices and key reports regarding claims, eligibility inquiries and authorization requests.

• Provider & Pharmacy Look-Up– Search the online Provider Directory by geographic location and medical specialty to refer members to in-network services.

• Provider Manuals–A complete copy of Harmony's Provider Manual is available online, including all necessary forms and educational materials.

Advantages of Registration for Providers:
The Harmony Web site allows providers to have as many administrative users as needed and can tailor views, downloading options and e-mail details. Providers may also create individual subaccounts for your staff, keeping separate billing and medical accounts.

HealthCare USA

Claims Processing – Timeliness of Claims Payment
The claims department at Healthcare USA maintained a focus for FY 2008 to assure that high quality claims metrics were achieved and maintained. In 2007, the claims department monitored claims processed within 15 days, claims processed within 30 days, days in inventory, pends % of inventory. For FY 2008, the CSO achieved and exceeded all production standards, except the percent pended.

Currently, the goals established are as followed:

- Claims Processed within 15 days: 92.5%
- Claims Processed within 30 Days   99%
- Days in Inventory: 2.5 Days
- Pends % of Inventory: 8.5%

Various system enhancements continue to be implemented in the HealthCare USA's claims processing area to ensure timely and accurate claim resolution for all claim types. Claims interest reports are reviewed and analyzed on a monthly and quarterly basis to identify any training issues related to claims payment or other opportunities for improvement.

Weekly quality meetings have been ongoing for FY 2008. Tracking and trending reports are run on a weekly, monthly, and/or quarterly basis to assess the following areas:
- High Dollar Errors
- Top Financial Errors
- Top Statistical Errors
- Top Errors by Examiner
- Modifiers
- GMIS
- COB
- Dollar Review
- Timeliness of Payment
- Adjustments
- Interest
- Quality
- Provider Billing Areas

Adjustment reports are analyzed and reviewed on a monthly and quarterly basis to identify adjustments by department, provider specialty, billing areas and claim status types. Employees receive feedback and additional training for ongoing professional development. Provider education is also completed when applicable.

Continuous ongoing training has been emphasized during FY 2008. Training topics are as follows:
- Claims Training
- Provider Billing Areas
- Adjustment Training
- COB Training
- Fatal Edit Training
- Navigator Training
- HIPPA Training
- Employee Rights
- Compliance and Ethics
- Fraud and Abuse
- Various Microsoft Applications

All new claims examiners receive a training class consisting of 8 to 9 weeks. They review provider selection, system overview, benefits, authorizations, navigator, remittance advice, GMIS, adjustments, ICD-9, CPT coding and COB. Cross training initiatives also took place in

2006-2007 between claims and customer service in an effort to maximize resources and gain efficiencies.

In addition to the above noted quality improvement initiatives, HealthCare USA's CSO has maintained outstanding service metrics with regards to both overall claim payment quality and timeliness throughout FY 2008. As we continue in 2008, the CSO is confident that by remaining focused on the day to day metrics, persistent application of enhancements and the continuous training of staff, HealthCare USA will continue to perform above expectations.
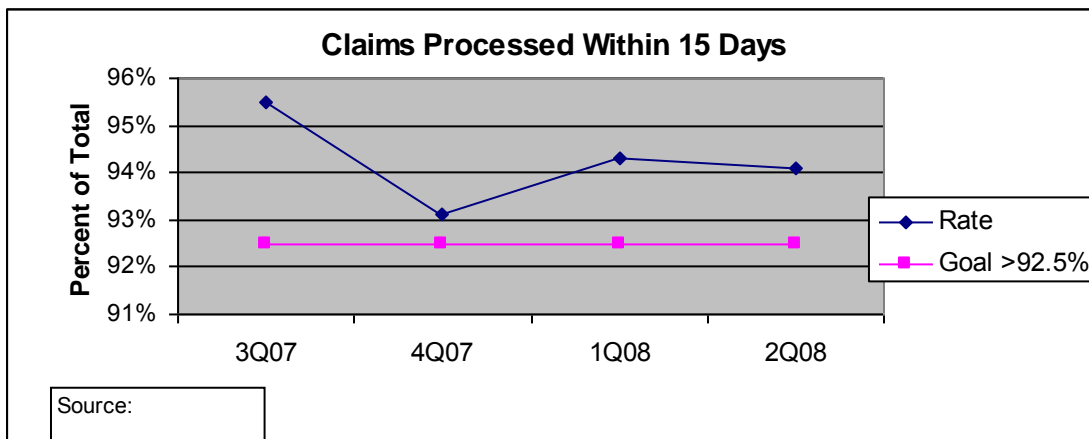
Claims Processed Within 15 Days

	3Q07	4Q07	1Q08	2Q08
Rate	95.5%	93.1%	94.3%	94.1%
Goal >92.5%	92.5%	92.5%	92.5%	92.5%

Source:

Continues to exceed goal.

Claims Processed Within 30 Days

	3Q07	4Q07	1Q08	2Q08
Rate	~100%	~99.8%	~100%	~100%
Goal >99%	99%	99%	99%	99%

Source:

Continues to exceed goal.

218

Days In Inventory

Continues to exceed goal.

Pended Claims Percent of Inventory
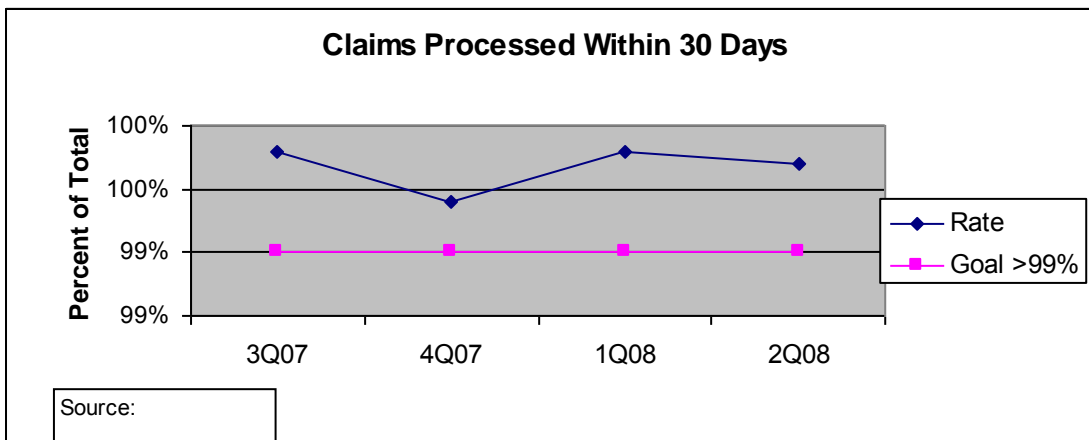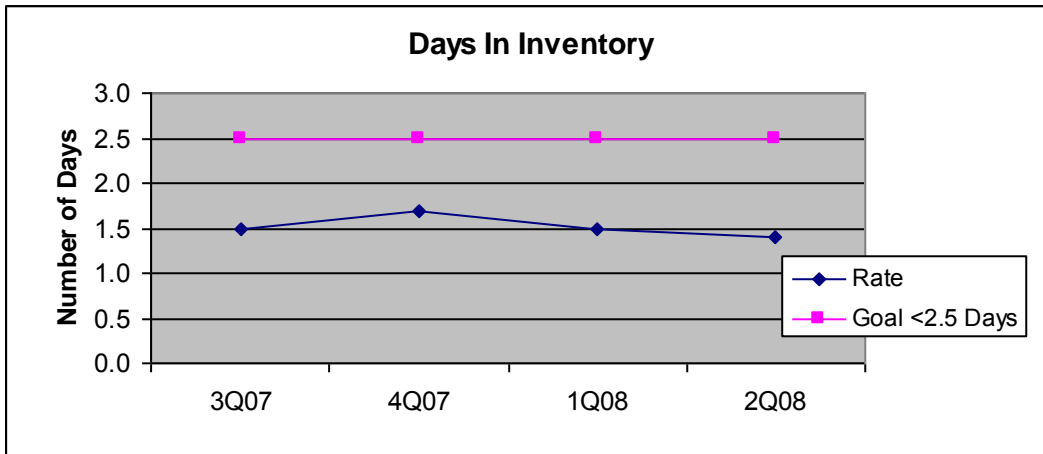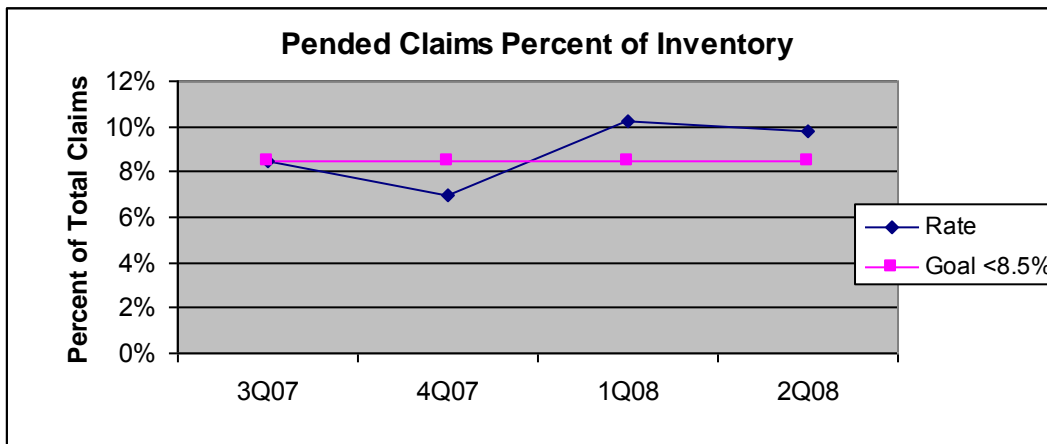
Rate for first and second quarters 2008 did not meet goal. During the 1st and 2nd quarter of 2008, we had several contracts that were being loaded and as a result, claims were forced to pend until testing and validation warranted that they could be released for processing.

Overall Claims Accuracy

Source:

Continues to exceed goal.

Overall Financial Accuracy

Source:

Continues to exceed goal.

Overall Payment Accuracy

Source:
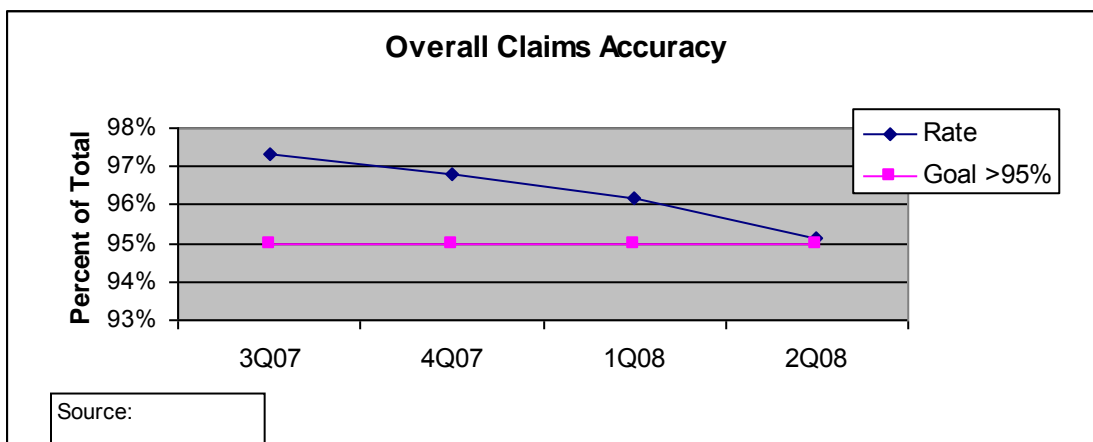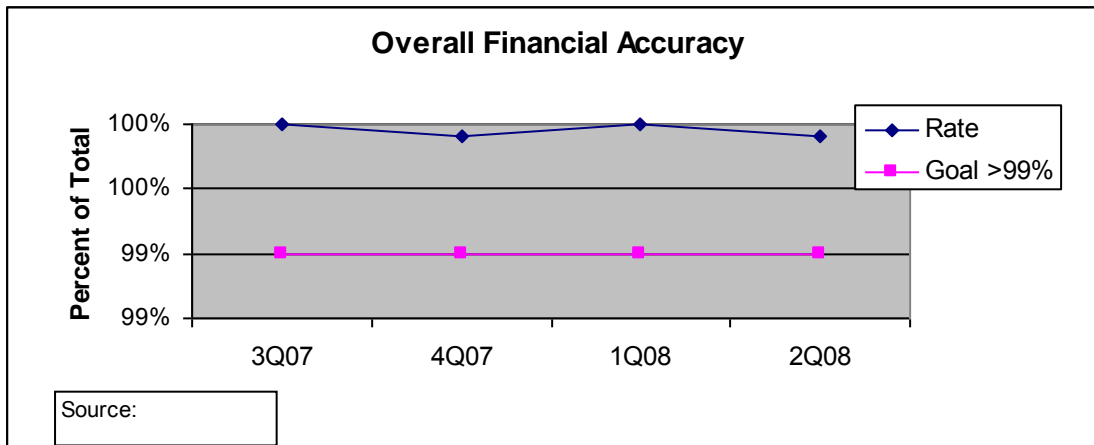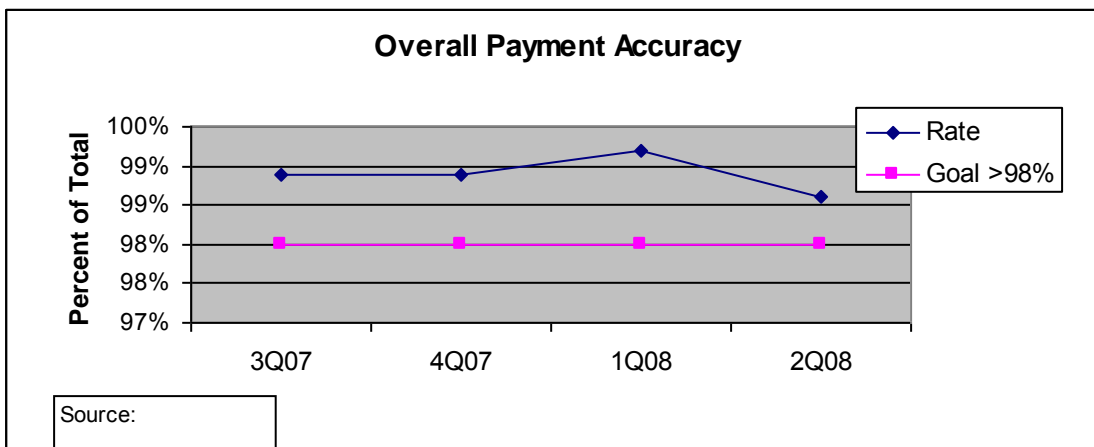
Continues to exceed goal.

Membership

The CSO handles all membership files for HealthCare USA. Files are downloaded daily from the State. Upon completion of this download, they are loaded and processed in the IDX software system. Listed below is a brief description of how each file is sent:

Reconciliation File:
HealthCare USA receives a reconciliation file from the State's IS Department (InfoCrossing) every Saturday. This file contains a snapshot of HealthCare USA's entire membership. This file is run every Monday or the first business day of the week only to add new members or term current members in the system.

Daily File:
HealthCare USA receives eligibility file from the State's IS Department (InfoCrossing) daily. This file contains all updates/changes on members' effective/termination dates as well as their demographic information. The file contains 3 components: an Eligibility file, a Health Assessment file, and a COB file. These files are loaded into an interface and processed each day.

Providers

PCP Assignment

All members are given the opportunity to select a PCP upon enrollment. Members receive an enrollment packet that contains the most current Member Handbook/Provider Directory to assist in the selection of a PCP. They are instructed to notify HealthCare USA, telephonically or by mail, of their choice of a PCP within fifteen (15) calendar days of receiving the enrollment packet from the state's enrollment broker. If no choice is made, a PCP is automatically assigned to them. Members can contact the CSO who can help members needing assistance in selecting a PCP.

Members that have disabling conditions or a chronic illness may request that their PCP be a specialist. The member's request to have a network specialist as a PCP is directed to the HealthCare USA's Medical Director for review. The requested specialist is contacted to inquire if he/she is willing to accept the additional responsibilities of a PCP prior to the approval of the request. The member is notified of the request determination verbally within ten (10) calendar days of the request. The written denial of a request is confirmed upon the verbal notification of the determination to the member. The written denial notification provides notice of the member's right to appeal and the process to initiate an appeal. The process for requesting a specialist as the PCP is not applicable to OB/GYNs when the OB/GYN has agreed to being the PCP for a member.

If the member does not select a PCP within fifteen (15) calendar days of receipt of their new enrollment packet, HealthCare USA makes an automatic assignment. HealthCare USA takes into consideration known factors and assigns the member to a provider that best meets the needs of the member. The factors considered include, but are not limited to: current provider relationship, age, language needs, location, special medical needs and panel size of the provider. If circumstances are such that the member does not have a PCP assigned on the effective date with HealthCare USA, HealthCare USA will not deny services or payment for any services.

HealthCare USA notifies the member of the PCP to whom they have been assigned. Members are given the opportunity to request a change of providers. The assignment of a new PCP under these circumstances is not considered as one (1) of the two (2) PCP changes allowed per year. HealthCare USA notifies the member of the PCP's name and address via the new member enrollment packet and the PCP's name and phone number via the member's HealthCare USA member ID card.

Maintenance of Provider Network Data

The Coventry Provider Database (CPD) is a windows-based IDX interface that is used across all Coventry plans. The CPD will integrate the following:

- Provider credentialing
- Provider maintenance
- Provider contract instructions
- Rental network specifications
- Directory profiles

The Coventry Provider Database has the following features:
- Single point of entry for provider information (physicians, hospitals and ancillary providers) stored on a centralized provider database
- Standardized credentialing process
- User-friendly mechanism for generating reports and extracts through Cognos
- Elimination of individual plan credentialing systems
- Incorporates the current Electronic Provider Information Form (EPIF) and the many systems associated with the form
- A method to proactively work towards increasing the quality of provider directories

Encounter Data Submission

HealthCare USA has been conducting a performance improvement project for encounter data since 2005. This project was to meet the State's requirement of a 95% acceptance rate for all encounters sent to the State. The project focuses both on acceptance of claims and completeness of claims. The original focus of the project was to meet the 95% acceptance rate. This was achieved in February 2005, and has been maintained since except for two (2) months when duplicate files were sent. The focus for 2007 was completeness of data. This project has maintained an acceptance rate at or above 95% throughout 2007 and through September 2008. Interventions made for the project are now a permanent process of the encounter data submission process.
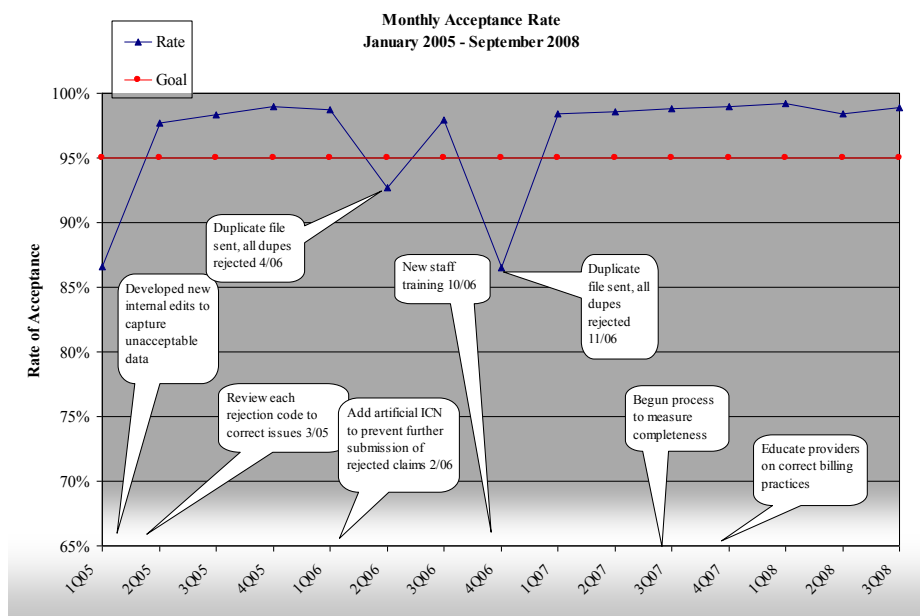
Source: MO HealthNet Encounter Data Report

Missouri Care

Claims Processing – Timeliness of Claims Payment

Missouri Care received 441,884 unique claims for fiscal year 2007. During the beginning of SFY 08, Missouri Care utilized the QMACS 4.10 claim processing system developed by QCSI. In January 2008, Missouri Care upgraded the claim processing system to QNXT 3.2, also developed by QCSI. The health plan did not experience any significant downtime or disruption to either claim processing platform in the measurement period. Missouri Care is constantly working to improve the accuracy and timeliness of claim payments. To achieve these objectives, our goals were to increase EDI claim submission percentage, increase mass adjudication and to decrease the turnaround time for clean claims payment. In 2007, on average, clean claims were paid in 11 days. Additionally, in 2007, Missouri Care's EDI claims percentage was 75%, a four percentage point increase over the 2006 rate of 71%. Missouri Care attributes the increase to ongoing outreach efforts with providers. The health plan also raised the mass adjudication rate from 75% in 2006 to 80% in 2007 by converting contracts to a standard payment template.

Membership

The Member Solutions Department performs daily and weekly audits to verify members' enrollments are correct in our system. The audits compare the State eligibility file to QNXT and then QNXT to the State eligibility file. These audits will capture any discrepancies in either file.

Providers

As part of daily operations, Provider Relations, Claims, Medical Management, and Quality Management staff monitors the accuracy of provider records in QNXT. All errors or necessary changes are reported to the appropriate Provider Relations staff so that corrections or updates can be properly submitted to the Provider Information Management (PIM) team. All PIM system activity is audited by the Provider Relations staff who initiated the change request.

Molina Healthcare of Missouri

Claims Processing – Timeliness of Claims Payment

DATE	% of Clean Claims Paid Within 30/days	Avg. Turnaround Time
JUL 07	98%	7.1
AUG 07	99%	5.6
SEP 07	99%	4.8
OCT 07	99%	6.3
NOV 07	99%	5.5
DEC 07	99%	5.5
JAN 08	96.8%	5.6
FEB 08	97.1%	5.8
MAR 08	97.7%	6.3
APR 08	97.5%	5.9
MAY 08	96.1%	5.6
JUN 08	98.8%	6.1

Membership

Membership Activity	Member Count Per State Report	New Members Added	Terminations
JUL 07	64,432	2,758	3,191
AUG 07	63,999	2,879	3,473
SEP 07	63,405	2,662	2,923
OCT 07	63,144	3,755	3,517
NOV 07	63,382	4,011	4,151
DEC 07	63,242	4,968	4,479
JAN 08	77,716	10,565	5,045
FEB 08	76,295	2,410	4,736
MAR 08	76,757	3,013	4,745
APR 08	76,945	2,737	5,236
MAY 08	75,389	2,409	4,090
JUN 08	74,587	2,232	4,397

Providers

Currently, MHMO has 2,285 participating primary care providers in its network.

Quality Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Provider Satisfaction

The input of contracted physicians is vital for evaluating the services that BCBSKC offers to providers and members. HMO Physician Satisfaction Surveys are conducted, analyzed, and reported to the Quality Council with appropriate recommendations and action plans.

Surveys were mailed to 2,214 physicians (specialists and primary care physicians) and office managers. The 2007 Physician Satisfaction Survey provided the following feedback:

Ninety four percent (94%) of the primary care physicians, 94% of specialists, and 99% of the office managers rated BCBSKC's overall service as Excellent, Very Good, or Good.

Ninety seven percent (97%) of the primary care physicians, 97% of specialists, and 98% of the office managers stated they would definitely or probably recommend BCBSKC to colleagues who were considering becoming network providers.

Care Coordination

Continuity and Coordination of Care – BCBSKC for BA+ has implemented a comprehensive and integrated care management model in place of the traditional medical management programs. The program is known as CareConnection, is built on the strengths of the core medical management functionality (Utilization and Case Management), and leverages state-of-the-art technology to integrate business processes, data and communications to allow a true patient-centric model across the care continuum. The scope of products and services included in the transition from traditional medical management include case management, chronic condition management, early detection of disease, prevention, and wellness. Using tools that enable us to identify members with future health risks such as predictive modeling and health risk assessments, we stratify members into risk categories, engage members in programs to reduce their health risks, proactively intervene with them and their physicians as appropriate, and evaluate the effectiveness of these programs.

BCBSKC/BA+ employs seven registered nurses, one dietitian, and one manager for the disease management programs. A dedicated registered nurse was hired to case manage the BA+ 0-6 year old population exclusively.

BCBSKC/BA+ measures network access and is compliant with section (4) of 20 CSR 400-7.095 for access and availability. The following is extracted from the Department of Insurance network approval letter of July 13, 2008.

Network Access	% of Members with Access to Services
Primary Care Physicians	100%
Specialist	100%
Facilities	99%
Ancillary Services	97%
Overall	99%

Case Management

Case management is a collaborative process with our members in which the care managers assess, plan, implement, coordinate, monitor, and evaluate options and services to meet the member's health needs through communication and available resources to promote quality, cost-effective outcomes. The Case Management program is telephonically based with on-site management as needed. It is a dynamic process of on-going relationship building, communication and collaboration with clients, families, physicians and health care providers. The case management staff works to promote the optimum level of health for our members through referrals to disease state management programs, network management, benefits management and educational support. Patients with chronic, catastrophic, high-risk, or high cost conditions are referred to the Case Management Program for facilitation of an individualized plan of care. The pro-active Case Manager serves as an ongoing patient advocate, ensuring coordination of care and maximizing resources required to meet the Member's short and long term goals. There are specialty nurse care managers for disease management, pediatrics, obstetrics, physical rehabilitation and transplants.

In FY2008, BA+ assisted 1,459 members with case management services. Four hundred forty- three members were discharged from case management services.

Disease Management Program

Healthy Companion Disease State Management – The Healthy Companion Program is an education and care management support program for members with chronic disease. For the BA+ population, the targeted disease states are asthma and chronic obstructive pulmonary disease (COPD).

Asthma Disease State Management Program –The intent of the Healthy Companion disease management program for asthma is to improve the health status of all BA+ members with chronic respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD) as evidenced by improvement in quality of life and functional status, and decreases in emergency room (ER) visits and inpatient (IP) admissions.

A related goal is to improve provider compliance with standards of care for asthma as evidenced by improvement in the annual HEDIS® measure for asthma and appropriate utilization of services.

2007 Accomplishments

    a. Completed eighth year of interventions for respiratory disease state management program with improvement in clinical, utilization and functional status outcomes for asthma and COPD;

b. Maintained member satisfaction with DSM programs. Member satisfaction remains high, exceeding 93% for respiratory program;

c. Promoted appropriate influenza vaccinations to members in Healthy Companion program. This was accomplished by distributing coupons for obtaining the vaccination at selected sites for those over age nine in the DSM programs. Those under nine years of age were sent letters encouraging them to go to their PCPs for the vaccination.

Outcomes: HEDIS measurements for diabetes and asthma using 2007 data show the initial impact of the Healthy Companion DSM program on its participants. Moving forward, BCBSKC is looking at new ways to work collaboratively with physicians as well as creating personalized educational materials to better assist members in exceeding the Performance Measures. HEDIS numbers will be one part of the clinical outcomes measurements in the 2008 report.

Mental Health Care Management including Case Management
Ambulatory Care – Mental Health
In 2004, New Directions began the Personal Transition Service (PTS) Program, which provides one in-home intervention from a licensed behavioral health practitioner within 72 hours of discharge from the hospital. New Directions has identified and contracted with local clinicians that provide in-home therapy. The in-home service they provide is a one-time follow up post-hospitalization visit. While visits typically take place in the member's home, an office visit option is offered.

Each member receiving inpatient care management is screened for referral to a licensed PTS Clinician by the assigned New Directions Care Coordinator. Based on the results of the screening, a PTS appointment is scheduled within 7 days of discharge. During the individual session, the PTS clinician:

1. Reviews medications prescribed and medication adherence.

2. Ascertains that follow-up visits have been scheduled.

3. Develops an individualized safety plan.

4. Coordinates with New Directions staff if an urgent appointment is needed.

A description of this program was submitted to the 2005 *NCQA HEDIS® Update and Best Practices Conference*. It was accepted due to the statistically significant change in HEDIS® ambulatory follow-up scores from FY2003 to FY2004. Lisa Woodring and Dr. Maureen Hennessey presented "Improving Patient Safety", a presentation that combined our Ambulatory Follow-up Program (including PTS) and Physician Notification Program. Below is a description of the results for BA+ discharge, including the effects of the PTS program on ambulatory discharge.

 In 2007, 323 BA+ members were discharged from inpatient care, not including those that stepped down to sub-acute or residential care.

• 241 members (75 percent) followed up within seven days

• 51 members (16 percent) had follow up appointments after seven days

• 25 members (7 percent) discharged to OON provider, C Star program, or refused

• 6 members (2 percent) discharged without follow up appointments

The following chart shows ambulatory results:
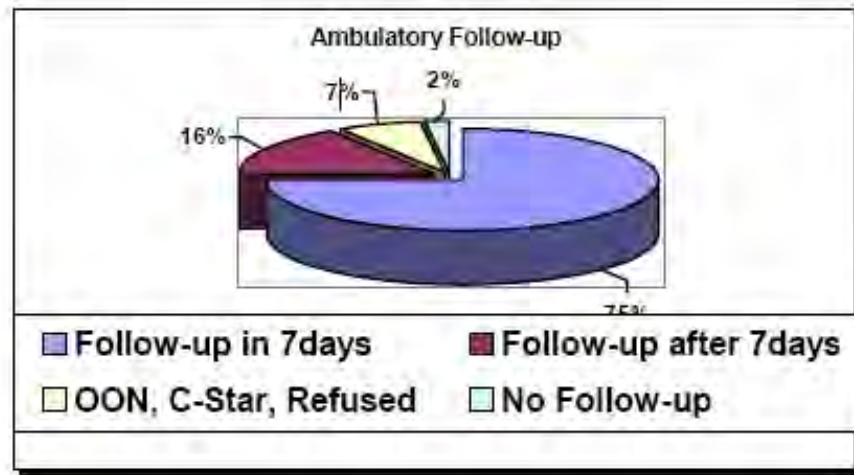
The New Directions Care Management Team tracks and trends the post-discharge care received by the remaining 25 percent of members. Many members discharge to C-STAR programs and/or out-of-network services because they receive intervention from DFS, DMH, or the legal system. New Directions continues to analyze barriers to ambulatory follow-up.

Of those receiving ambulatory follow-up in 7 days, New Directions provided services as follows, with 14% of these members receiving a PTS intervention, as follows:

Percentage of BA+ Members Using PTS Services

14%

23%

63%

☐ Follow-up in 7 days ■ PTS ☐ Partial, IOP
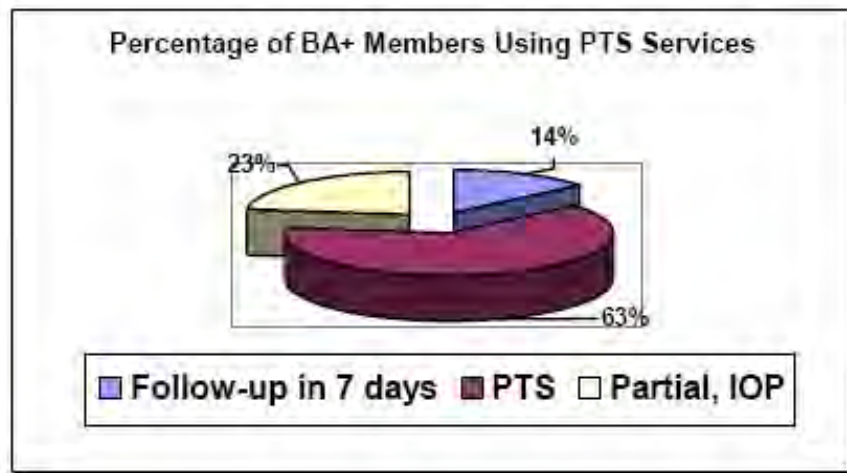
Family Evaluation/Therapy for Adolescent/Child Members—Mental Health
New Directions offers BA+ members the Parents and Children Together (PACT) program, which contributes to improved mental health status by providing intensive, in-home care and case management. A small group of affiliate clinicians that also do in-home therapy have been credentialed to address geographical gaps in the PACT program. The goals of this program include:

1. Intervention with the family system.

2. Sustained medication adherence as needed.

3. Appropriate monitoring of symptoms and changes in condition in the member's (family's) natural context.

4. Motivation for treatment and self-care among individuals at risk for relapse.

A typical case for in-home therapy involves a youth with a behavioral health disorder, compounded by multiple family problems. The behavioral health pathology may lead to the youth's refusal to cooperate with outpatient treatment recommendations. This may lead to an acute episode of the behavioral health problem. Aggressive behaviors and anger outbursts are not unusual. Families have financial limitations and may not have easy access to transportation.

The need for a more intensive level of care increases when the family cannot follow outpatient recommendations. Often, in-home intensive family therapy is used to avert a crisis situation. In other cases, residential or inpatient care has already been provided, and the in-home therapist is asked to provide ongoing care.

When the therapist can go into the home, the family is not burdened to find transportation and get the youth to the appointment. Once in the home, the therapist can intervene in an environment that promotes more ―natural‖ behaviors than those seen in a professional office. This type of intervention, which is both intense and based on ―teachable‖ situations, is effective in preventing crises, relapse, and readmissions.

New Directions contracted with two facilities in 2008 to offer up to 72 hours of respite care services for children and adolescents during times of crisis. During respite, in-home therapy is introduced and the crisis averted.

In some cases, New Directions calls on our clinicians who provide in-home therapy to intervene with adults. In one recent case, a woman with diabetes and heart disease was admitted with a medication overdose due to depression and anxiety. New Directions worked closely with the BCBSKC medical case manager to address concerns about the management of her diabetes and anxiety. An in-home therapist helped by providing emotional support and encouragement to follow medical advice. Coordination of care occurred between all providers involved. As a result, a readmission for psychiatric inpatient hospitalization was avoided.

In some instances, the in-home clinicians find a need for urgent services during a home visit. The clinician then contacts New Directions for immediate assistance, often averting an emerging crisis. In 2007, 126 BA+ Members benefited from in-home services.

Clinical Practice Guidelines
Clinical Guidelines apply to all managed care network physicians of applicable specialty. These are approved biennially by the Care Connections Advisory Committee (CCAC), and revised for approval as needed based upon updated clinical information from network practitioners and national organizations:

a. AAP – American Academy of Pediatrics

b. AAFP – American Academy of Family Physicians

c. AHRQ – Agency for Healthcare Research and Quality.

d. ACOG – American College of Obstetrics and Gynecology

e. ADA – American Diabetes Association

f. NHLBI – National Heart, Lung and Blood Institute

g. USPHSTF –United States Preventive Services Task Force

HMO physician compliance with clinical guidelines is assessed annually for a minimum of three distinct guidelines including one behavioral health guideline. Results are reported to the Quality Council with analysis and recommendations.

Credentialing and Re-Credentialing
The BCBSKC Corporate Credentials Committee policies ensure that network providers are qualified to provide health services to members. The BCBSKC Credentialing policies and procedures meet the following objectives:

a. To ensure that MO HealthNet Members who enroll will have their care rendered by appropriately qualified credentialed providers.

b. To ensure that each provider application has equal consideration for eligibility to participate in the BA+ network in accordance with applicable laws and accreditation standards.

c. To ensure that adequate information pertaining to education, training, licensure, experience, malpractice and other relevant information is reviewed by the appropriate individuals and departments within BCBSKC prior to approval or denial by the Credentials Committee.

All M.D.s, D.O.s, D.P.M.s, D.C.s, D.D.S.s and other licensed independent practitioners who provide covered health care services to members and are or will be listed in the BCBSKC provider directories shall undergo the credentialing and recredentialing process according to the criteria outlined in the Professional Provider Credentialing Policy. Credentialing and recredentialing of HMO primary care practitioners and OB/GYNs includes an on-site assessment of the office environment and medical record-keeping practices in accordance with the Office Site Assessment Policy.

Institutional providers, (i.e. Hospitals, Home Health Agencies, Extended Care Facilities, and Ambulatory Care Centers) are credentialed and recredentialed in accordance with the Institutional Credentialing Policy.

URAC awarded BCBSKC-BA+, a Certificate of Full Accreditation for compliance with Health Provider Credentialing Standards, version 3.0 effective March 1, 2007 through March 1, 2010.

Medical Record Review
Eight standards that have not historically scored well in the past were chosen for this random survey. The goal of at least 80% was met by one criterion – blood pressure during the year for anyone 18 years or older diagnosed with hypertension. There were however, no statistical changes in the scores between 2007 and 2008 except for documentation of primary language which was not located on any charts.

The chart below indicates the scores for the eight standards that were used in the random survey.

QID	Question Text	Score	Possible	Percentage
63329	Adult Immunizations documented	69	134	51.49
63338	Comprehensive physical examination	87	147	59.18
63359	Documentation of depression screening for members with chronic conditions such as diabetes, chronic pain, COPD, heart disease, etc	37	140	26.43
63336	Documentation of inquiry/counseling regarding tobacco habits	115	148	77.7
63360	If 18 or older, with no diagnoses for hypertension, there is a documented blood pressure reading during 2007	65	75	86.67
63320	Personal biographical data includes primary language	0	148	0
63319	Personal biographical data includes race/ethnicity	12	148	8.11
63321	Record contains problem list of all current/unresolved problems	116	148	

Recommendations will made later in the year after the MRDR standards have been reviewed.

Subcontractor Monitoring

BA+ can delegate the authority to perform health plan functions on its behalf; however, it cannot and does not delegate the responsibility for insuring that the functions are performed appropriately. To ensure that the quality of care and services provided on behalf of BA+ is maintained, functions will be delegated to only those entities meeting or exceeding BA+ standards. In addition, the State Programs Department has a comprehensive compliance program, including requirements for documentation submission. Compliance with contract requirements is taken very seriously at BA+. Analysis of compliance is completed at least annually and more frequently if required.

The Delegated Oversight Committee Chair, responsible for pre-delegation assessment of potential subcontractors, will notify the BA+ Plan Administrator of the desire to subcontract with a new entity. The BA+ Plan Administrator will notify the MO HealthNet Division, providing all requested information. The BA+ Plan Administrator will notify the Delegated Oversight Committee Chair of the decision of the State upon receipt of notification. An implementation plan will be developed, including consideration for transition of care and notification to the members.

BCBSKC and the subcontracting entities have signed agreements before providing services to BA+ members. All agreements provide a description of the services to be fulfilled by the entity. Included in the services that need to be provided to members are State and Federal requirements, and delegation requirements. BCBSKC may choose to delegate specific responsibilities to the entity at BCBSKC's discretion. If delegation is agreed upon, the responsibilities delegated are overseen and audited through the Delegated Oversight Committee at BCBSKC – managed through the Quality Management Department. Delegation agreements are reviewed annually for compliance of expected outcomes.

New Directions Behavioral Health, L.L.C.
Type of Service: Behavioral Health – Provide all covered mental health services to all BA+ members, with the exception of the COA4 members (coverage of these members is covered by the State of Missouri Division of Medical Services).

Delegation Assignment: Claims, Utilization Management, Member Grievances and Appeals, Provider Complaints, Case Management, Credentialing and Quality Management, Care Coordination

Doral Dental
Type of Service: Dental Services – Provide all covered dental care services to all BA+ members having dental benefits.

Delegation Assignment: Claims, Utilization Management
In FY2008, credentialing services were removed from delegation. BCBSKC resumed credentialing services after several attempts to correct the problem of timely and accurate credentialing.

Medical Transportation Management
Type of Service: Medical Transportation – Provide non-emergent transportation services to BA+ members having transportation benefits.

Delegation Assignment: N/A

Corrective Action: MTM was on corrective action during FY 2008, for not meeting the abandonment rate (no greater than 5%) and speed to answer (no greater than 30 seconds) goals. MTM has been on corrective action since December 29, 2005. BA+ meets with MTM monthly to review abandonment rates and speed to answer timeliness. BA+ is working closely with MTM to resolve this corrective action.

MTM successfully met the abandonment rate and speed to answer goals for six continuous months. The corrective action plan was closed at the March 2008 meeting. MTM resolved this issue by implementing a retention program, hiring more staff, and making all BA+ calls the highest priority.

Corrective Action: In August 2007, MTM was placed on corrective action for not providing 24/7 non-emergent transportation service 100% of the time for BA+ members. MTM has increased their staff, provided training, increased their number of vendors, and increased their hours to make sure there is 24/7 coverage. BA+ is monitoring and working closely with MTM to resolve this corrective action.

Corrective Action: In February 2008, MTM was placed on corrective action due to monthly encounters not submitted to State Programs Department within timely submission guidelines. According to the contract, encounters must be sent to BCBSKC on a monthly basis within 45 days after the end of the month. BA+ will monitor and work closely with MTM to resolve this corrective action.

The subcontractor contracts are managed within the Provider Services and Medical Services Departments of BCBSKC for BA+.

Children's Mercy Family Health Partners

Provider Satisfaction
Children's Mercy Family Health Partners has revised our provider satisfaction survey and will be conducting the survey in 2009.

Although a formal survey has not been done recently we expect provider satisfaction is high within our network for several reasons. We have implemented process changes that have expedited payment to our providers with weekly claims payment cycle which increases the cash flow to our provider and thereby decreases their accounts receivable.

We have introduced direct claims submission through our website at no cost to our providers. They no longer have the cost associated with a clearinghouse if they filed electronically. For those providers who previously filed claims on paper, this allows a more timely receipt and processing of claims. We have gotten very positive feedback on this enhancement.

We recently redesigned our provider remittance advices based on provider feedback to make it easier to read and use for internal accounting which should enhance provider satisfaction.

CMFHP continues the pay for performance initiative with our Primary Care Physicians, providing an increased administrative capitation payment for those who qualify. Those PCPs who do better than their peers providing immunizations and lead testing to our members can increase their base administrative capitation payment. This is reevaluated annually.

Based on the comments that our provider relations representatives hear during their office visits and complements heard when we attend provider functions, the physicians appear to be very satisfied with CMFHP. We will see if these thoughts are validated during our next survey the first quarter of calendar year 2009.

Care Coordination
Case Management
Care management is an important component of medical management at Children's Mercy Family Health Partners (CMFHP). The goal of care management is to assist in facilitating healthcare services that are cost-effective, timely, and delivered in the most appropriate environment.

Children's Mercy Family Health Partner's Care Managers are structured into teams for High Risk OB, Special Health Care Needs, Lead Toxicity, Emergency Room Use, as well as categories for Pediatrics and Adults. The Manager of Clinical Services directs the day-to-day operations of care management, with oversight from the Chief Clinical Officer and the Medical Directors.

CMFHP continuously reviews the way we identify members, the processes for interventions, the documentation of those interventions, and the measurement of outcomes. In 2005, CMFHP implemented a care management audit process to ensure consistency in documentation and adherence to standards. CMFHP successfully implemented new, more comprehensive assessment forms, documentation standards, and audit forms for all care management specialty areas in 2005. The first audits performed in 2nd quarter 2005 allowed Health Services management to revise the form and educate staff regarding application of the new documentation and assessment standards. A quarterly audit process is now in place to evaluate each Care Manager's adherence to standards and application of guidelines.

In addition, CMFHP evaluated its current care management database and determined that a new software system was needed to support care management activities and provide functionality, such as reminder systems, to improve the care management process. The CARE (Case Assessment and Referral Evaluation) system was developed throughout 2006 and implemented in 2007. In 2008, additional enhancements, including online referrals to the Medical Directors and integration with claims and authorization systems were under development. The enhanced version is expected to be tested and released in early 2009.

Below are highlights of two of the CMFHP Care Management Initiatives in 2008:

Health Literacy
In 2007, the Care Management department began a program for health literacy education of mothers with children ages 0-6 years of age. The program was developed by UCLA and Johnson and Johnson ―Health Care Institute" and offered initially to all Kansas Head Start programs. Parents received training on the use of the book ―What to Do When Your Child Gets Sick", followed by a monthly reinforcement over a three month period. At the end of that period, over 85%of parents reported using the book and having increased confidence in caring for their children's minor illnesses and injuries*. The programs report a 40% reduction in children's emergency room visits and a 39% decrease in doctor/clinic visits*. (*as reported from Robin Gingrich, educator for the Head Start Health Literacy Program).

In response to a high level of interest from public health partners, the United Methodist Health Ministry Fund, supported a grant to develop a new training program, still incorporating the use of the book, ―What to Do When Your Child Gets Sick" written by Gloria Mayer, R.N. and Ann Kuklierus, R.N. This book is written at the fourth grade level and discusses health concerns of children ages birth to 10 years.

CMFHP discovered this program when it was introduced during a Community Advocacy Meeting. The goal of this project is to increase the participant's health literacy while promoting optimal health outcomes. The focus of the CMFHP Health Literacy program is on educating the participants on the use of the book. The program presenters attended a 3 hour training course presented by Robin Gingrich, educator for the Job Corp Vocational Literacy Project and a former Elementary School Teacher. The training program focused on the definition of health literacy, the impact of low health literacy on families, communities and society as a whole and research-based effective instruction with low-literacy parents.

CMFHP has conducted two health literacy programs with plans to complete two additional programs by the end of 2008. The attendees are requested to complete a post program evaluation consisting of questions asking if the training was helpful, if the participant will use the book, if they would recommend this book to their friends and a final question requesting feedback about what they would change about the day's presentation. The results of the post program evaluation indicated the training as very helpful, and they would definitely use and tell their friends about the book.

Due to initial low participation rates in the first two programs (one participant attended each session), CMFHP is looking for alternative venues to teach the program. One venue that will be tried in 4th Q 2008 is to teach the program to CMFHP mothers who have a child in the NICU. Additional creative ways to teach the program are being pursued with the CMFHP Pediatric Care Management team as the primary educators of the program.

Emergency Room (ER) Care Management
Since 2005, CMFHP has conducted an onsite care management intervention at one of its largest safety net adult hospitals, Truman Medical Center (TMC). Interventions involve the following:

- Onsite Care Manager at TMC 4 hours/day
- Assess member's knowledge of health/treatment, educate members post treatment
- Redirect after treatment to Primary Care Provider (PCP)
- Assist with appointments if needed
- Educate/assist with transportation
- Educate on pharmacy provider and process
- Educate on use of Urgent Care Centers
- Conduct follow up calls post ER visit to assess needs, adherence to plan of care/follow up and assist member as needed

In addition to the above onsite intervention, in late 2007 and early 2008, CMFHP added additional telephonic ER interventions at several high volume hospitals in the area, including St. Luke's Hospital, St. Luke's Northland, Liberty Hospital, and St. Joseph Health Center. These facilities send the CMFHP care management department a daily report of ER visits from the previous day. Those reports are screened to identify non-emergent visits during normal PCP hours (Monday through Friday, 8am-5pm). Members who meet the criteria are called by a Care Manager for education on alternatives to the use of the ER and the importance of establishing a PCP. Similar education and interventions are conducted as with the onsite Care Manager, in that barriers are identified and when possible, eliminated, to encourage ongoing use of primary care in lieu of emergency room care for non-urgent/non-emergent needs.

Disease Management Program
The Children's Mercy Family Health Partners Disease Management programs were developed by clinical experts and use a unique approach to manage chronic disease. Rather than relying exclusively on phone consultations or patient education materials, our community educators form special relationships with primary care providers (PCP's) to help them implement comprehensive disease management in their offices leading to improved patient health and reduced costs.

The Children's Mercy Family Health Partners Disease Management program consists of the following highly integrated components:

- Physician office education
- Data analysis and reporting
- Stratified interventions
- Disease-specific Health Coaching
- Environmental assessment
- Provider incentives

By integrating these elements into a comprehensive program, we have demonstrated financial and clinical benefits, including reduction of health care utilization and increased provider satisfaction and patient quality of life.

Because there are no universal criteria for labeling a patient with a chronic disease, we use our database to identify participants who either have been diagnosed with a chronic disease or who have a condition that may lead to a chronic disease at some time in the future. To do this, we use a combination of claims data, hospital encounters, and pharmaceutical use or lab tests. By identifying participants with a chronic disease early, we can be proactive to promote activities that help maintain good control of their illness and lower acute care utilization.

Provider offices are selected based on the number of health plan participants in their participant panel. In this way, the largest number of participants can be affected by the program in the shortest amount of time. As more offices are trained, more participants receive the benefits of high quality and consistent chronic disease management.

Participant Population

Children's Mercy Family Health Partners (CMFHP) experienced a decline in membership from a high of 51,873 active participants at the end of 2004 to 41,883 by the third quarter of 2006. Membership has seen a slight increase since the beginning of 2007.

CMFHP MEMBER POPULATION
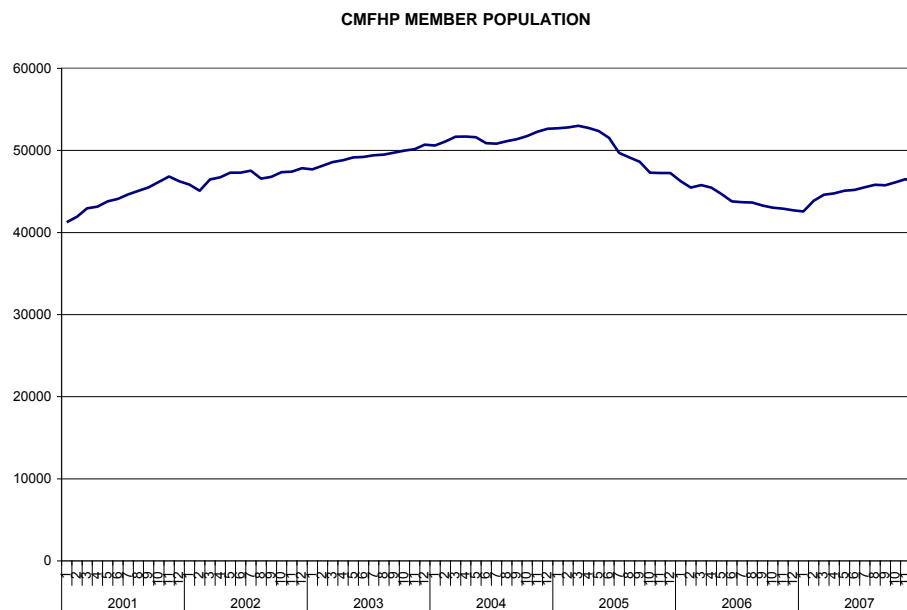
ASTHMA MANAGEMENT PROGRAM

Percent Participants with Asthma by Age Group

The percent of participants with asthma clearly varies with age. The chart below demonstrates an increase in diagnosis since the inception of the Asthma Management Program in 2002. It is the objective of our in-office education to increase awareness of asthma and promote the appropriate

diagnosis of asthma which has resulted in better diagnosis and treatment of participants with asthma.

PERCENTAGE OF MEMBERS WITH ASTHMA BY AGE GROUP
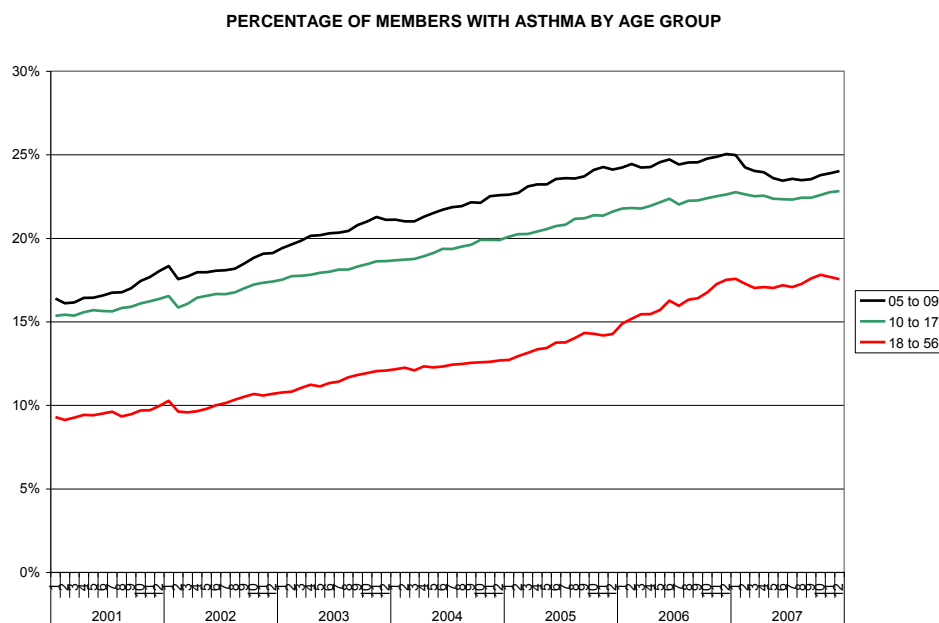
Providers Completing the Intervention (Asthma)

A total of 102 or 31% Missouri providers contracted with CMFHP in the Western Region have completed the Asthma Management Program.

Providers Participating in Asthma Program
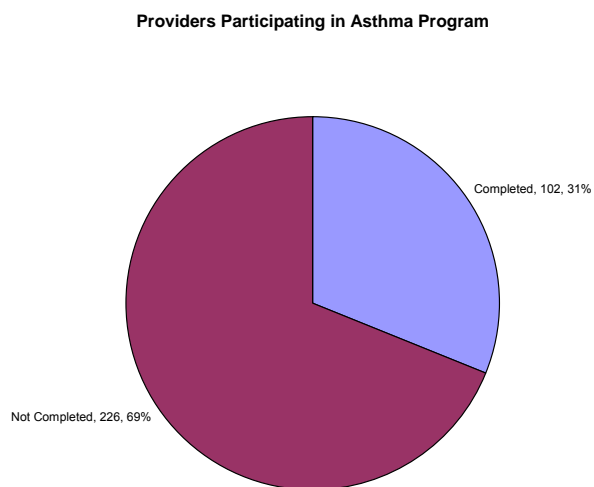
Patients Affected by Participating Offices (Asthma)

The 31% of the providers contracted with CMFHP in the Western Region who have completed the Asthma Management Program provide care for 66% of our participants.

Participants Impacted Through Provider Education

Not Completed, 15824, 34%

Completed, 31233, 66%
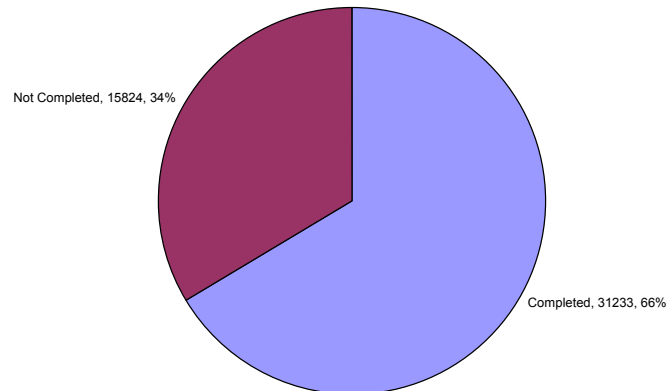
Asthma Action Plans

The number of participants who have an asthma action plan is shown below. This number continues to increase over time. At this time, over 5,000 plans have been given to over 3,000 participants. The difference is because some participants have received more than one plan, most likely related to changes in their asthma status or treatment needs. Action plans are an important tool for controlling asthma utilization. Since a major focus of the education for providers and staff involves the use of action plans, this is a good demonstration of behavior change. Initially, few or no providers provided action plans to their patients. After completing the program, the number of action plans increases to a different extent for each office and provider. We continue to advocate for provision of action plans with the goal that every participant with asthma has a written action plan.

Members with Action Plans
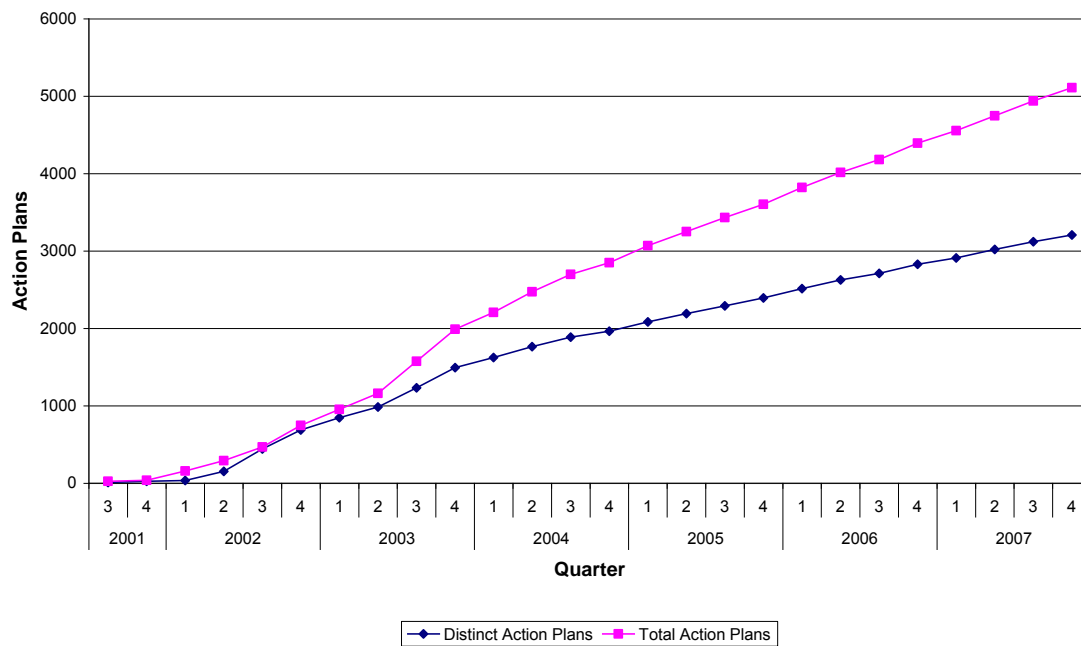
Emergency Dept. Visits and Hospitalizations for Asthma per 1000 Participants

CMFHP participants with asthma have had an overall decrease of 18% in emergency room utilization per 1000 participants for asthma from 2001 through mid-year 2008. Similarly, CMFHP participants with asthma have had an overall decrease of 7% in hospitalization per 1000 participants for asthma during the same time period.

Members with Asthma with ER Utilization Per 1000 Members
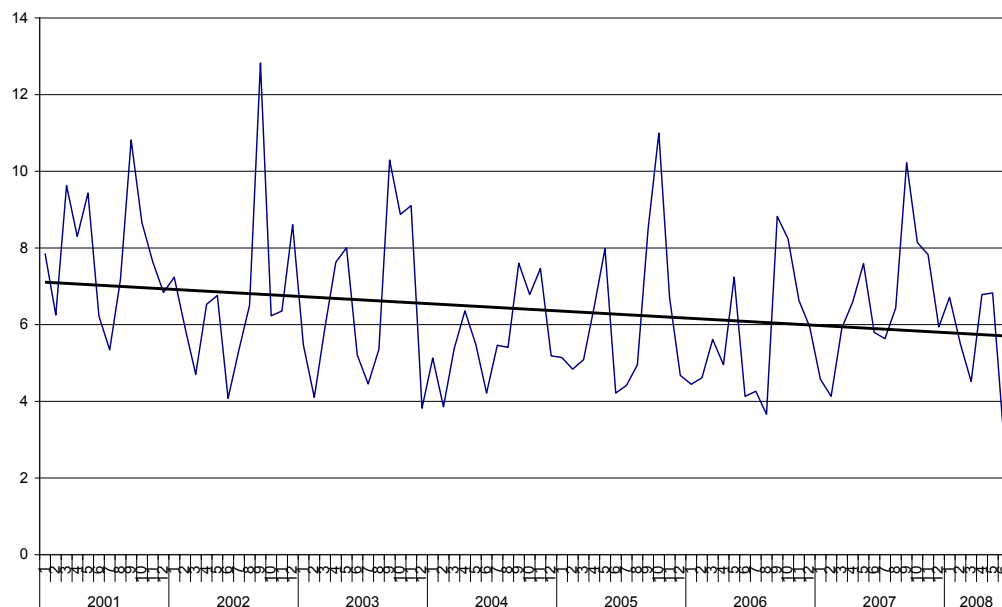
Asthma Hospitalization Per 1000 Members
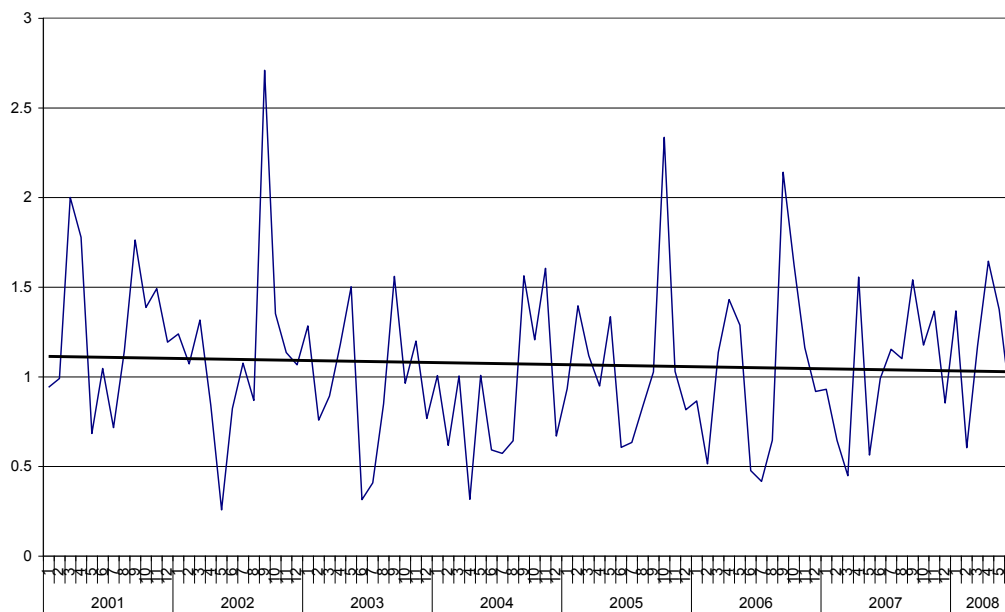
Percent of Participants with Asthma with ED Visit and Hospitalization for Asthma

The percentage of CMFHP participants with asthma who have used the emergency room for asthma has decreased by 46% from 2001 through mid-year 2008. Similarly, the percentage of

241

CMFHP participants with asthma who have been hospitalized for asthma has decreased by 31% during the same time period.

Percent of Members with Asthma with ER Utilization for Asthma

Percent of Members with Asthma with Hospitalization for Asthma
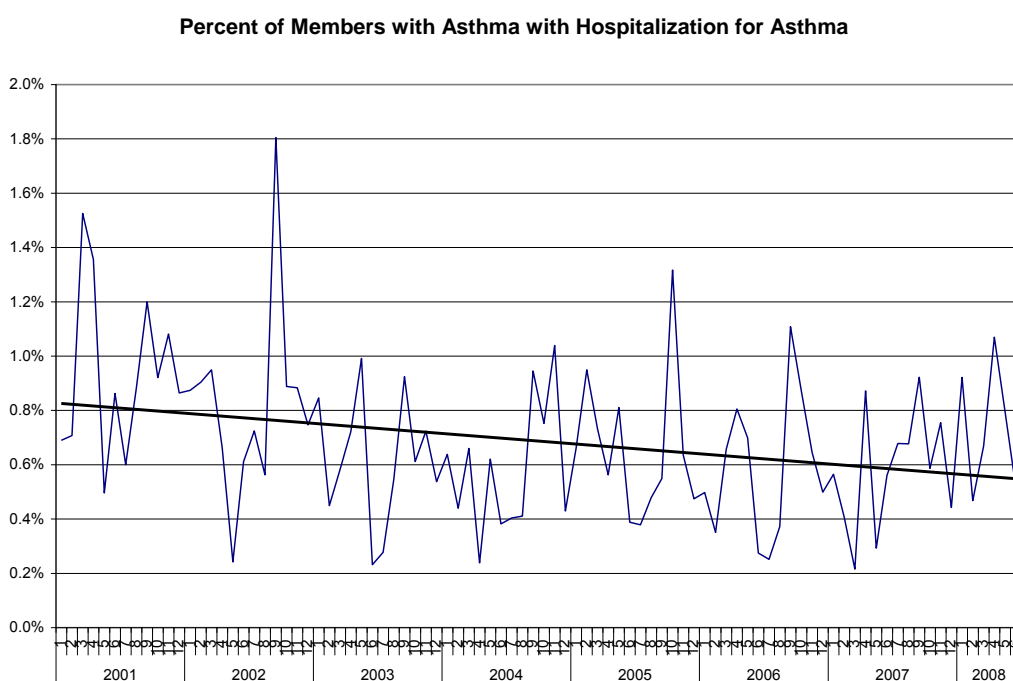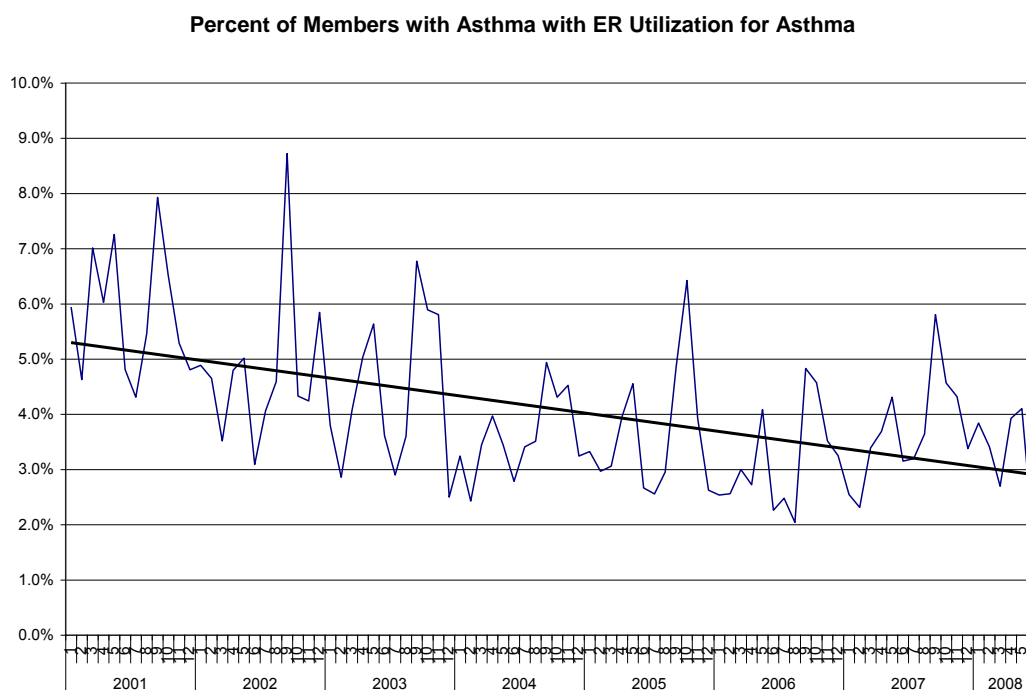
Population Health

There are numerous ways to measure cost. The most common way to determine the cost for utilization in a health plan is to divide the total cost of encounters for a particular condition by

the total number of active health plan participants who have that condition. Most cost assessments are stated on a per-month basis.

Total costs per Member per Month (PMPM)

The total cost PMPM for the health plan is shown below. The reason we have included this information is so that the asthma-specific cost information can be compared to the total population costs as a reference. As demonstrated by the trend line in the following charts, costs PMPM are increasing.

Cost Per Member Per Month
(Excluding Pharmacy Costs)
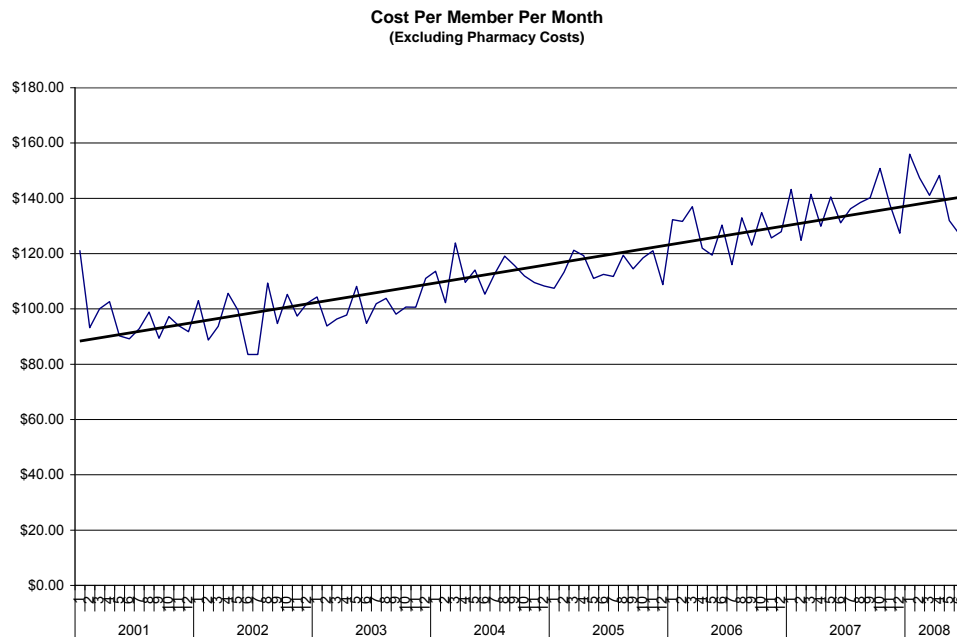
Asthma Costs per Asthmatic per Month (PAPM)

Overall, CMFHP has seen asthma costs for its asthmatic participants decrease nearly 14% per member per month from 2000 to 2007.

Cost Per Asthmatic Per Month
(Excluding Pharmacy)

Asthma Costs Per Asthmatic Per Month (PAPM)
(Excluding Pharmacy Costs)
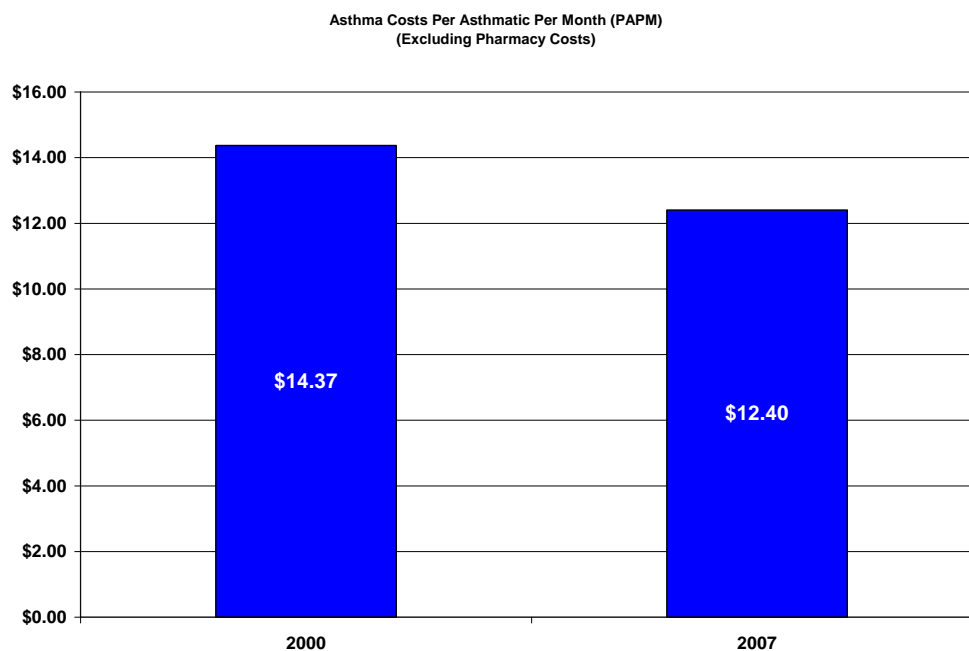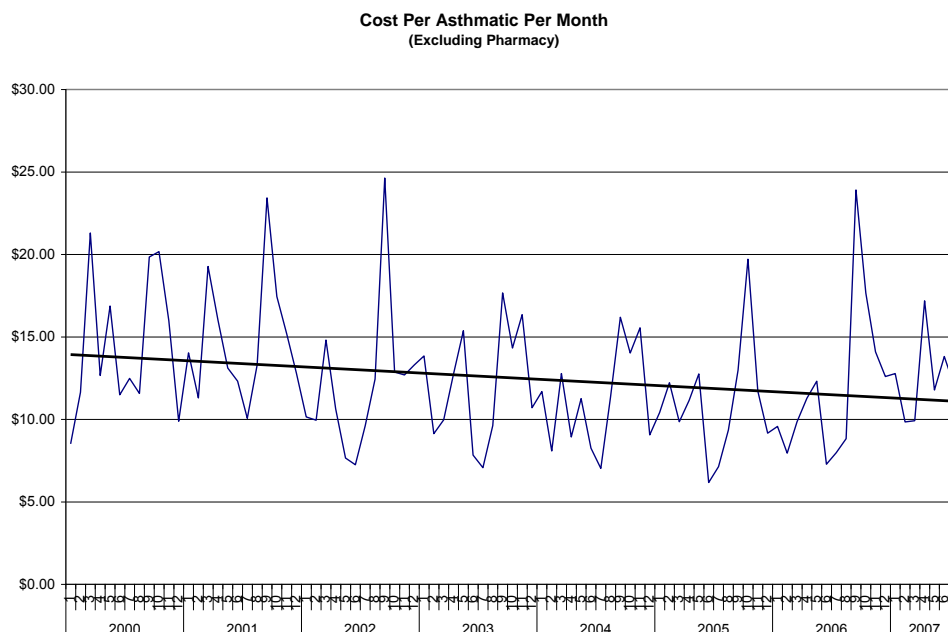
HEALTHY LIFESTYLES PROGRAM (HeLP)

Percent of Participants with Obesity by Age Group

The percent of participants diagnosed with obesity clearly varies with age. The overall percentage of participants diagnosed with obesity is 3%. When viewed by age group, the highest percentage is found in adult participants. The overall percentage of obesity diagnosis has increase very slightly over the last two years. These percentages establish the baseline for the

Healthy Lifestyles Program (HeLP) as we begin implementation in the primary care setting and offering Health Coach services to participants. It is expected that diagnosis of obesity will rise with continued education of providers and staff.

Percent Members with Obesity by Age Group
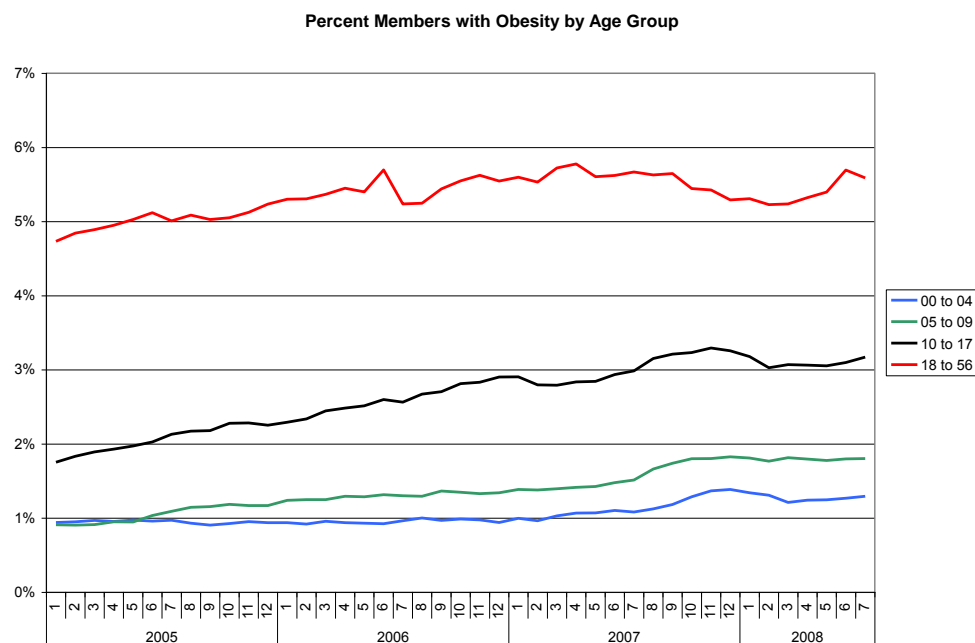
Providers Completing the Intervention (HeLP)

We have 8% of the offices contracted with CMFHP in the Western Region participating in the program which impacts 23% of the CMFHP participant population in Missouri.

Providers Participating in Healthy Lifestyles Program

Completed, 26, 8%

Not Completed, 302, 92%
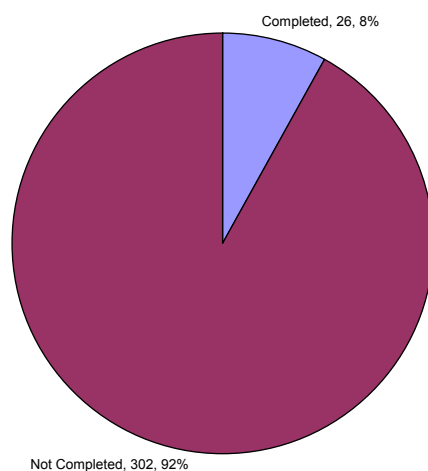
Participants Affected by Participating Offices (HeLP)

Participants Impacted Through Provider Education

Completed, 10775, 23%

Not Completed, 36282, 77%
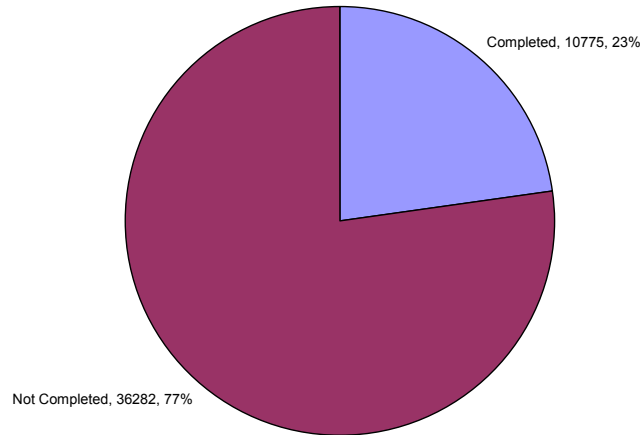
Health Habits Assessment

The number of participants who have a Health Habits Assessment is shown in the chart below. This number continues to increase over time. At this time nearly 1,000 plans have been given to participants. The Health Habits Assessment (HHA) is an important tool for obesity education. Since a major focus of the education for providers and staff involves the use of the HHA, this is a good demonstration of behavior change over time. HHA's are provided to all participants, regardless of weight. Therefore, the Percent Obesity (HHA) chart provides a look at the number of obese participants that are being reported from the PCP offices. We can compare the nearly 20% reflected in this chart with the number diagnosed on the previous chart which was 3%. We continue to advocate for provision of HHA's with the goal that every participant receives an HHA.

PARTICIPANTS WITH HEALTH HABITS ASSESSMENT
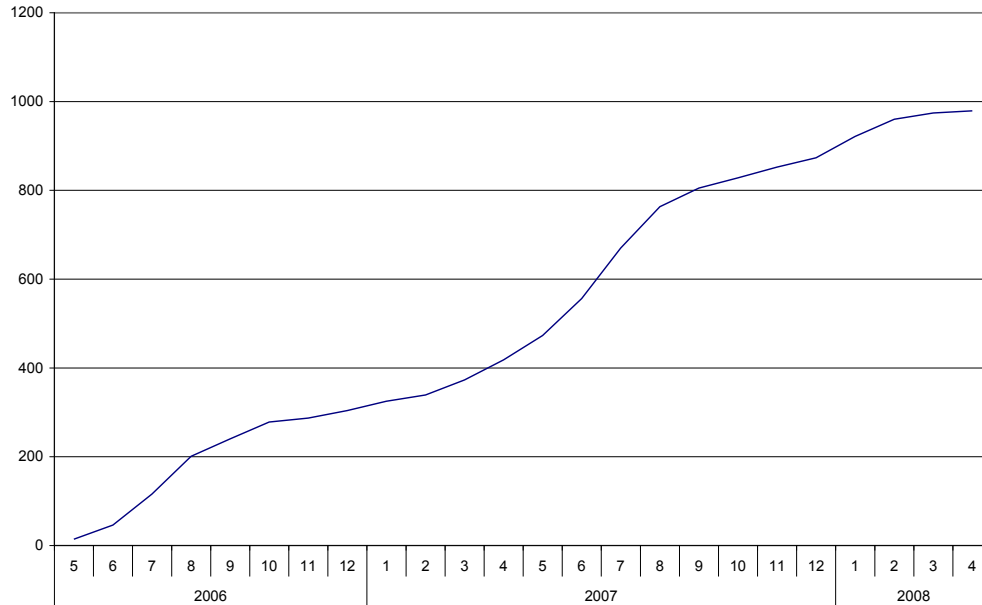
PERCENT OBESITY BASED ON HEALTH HABITS ASSESSMENT
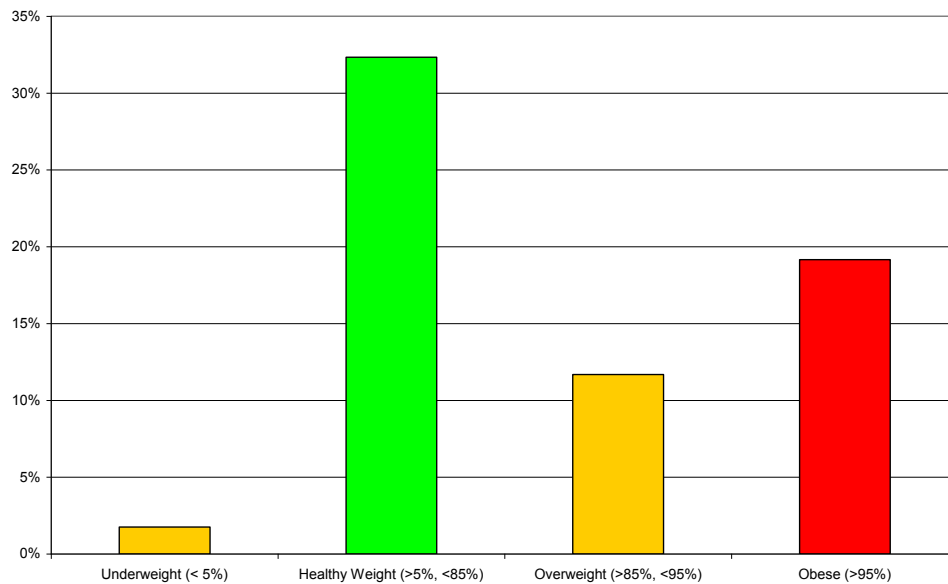
Participants with Diagnosis of Obesity with Appropriate Lab Testing

This measure demonstrates the percent of participants diagnosed with obesity who received appropriate lab tests. This is based upon the total number of participants diagnosed with obesity. It is the goal of the program to have all participants diagnosed with obesity receive these lab tests provided by their PCP.
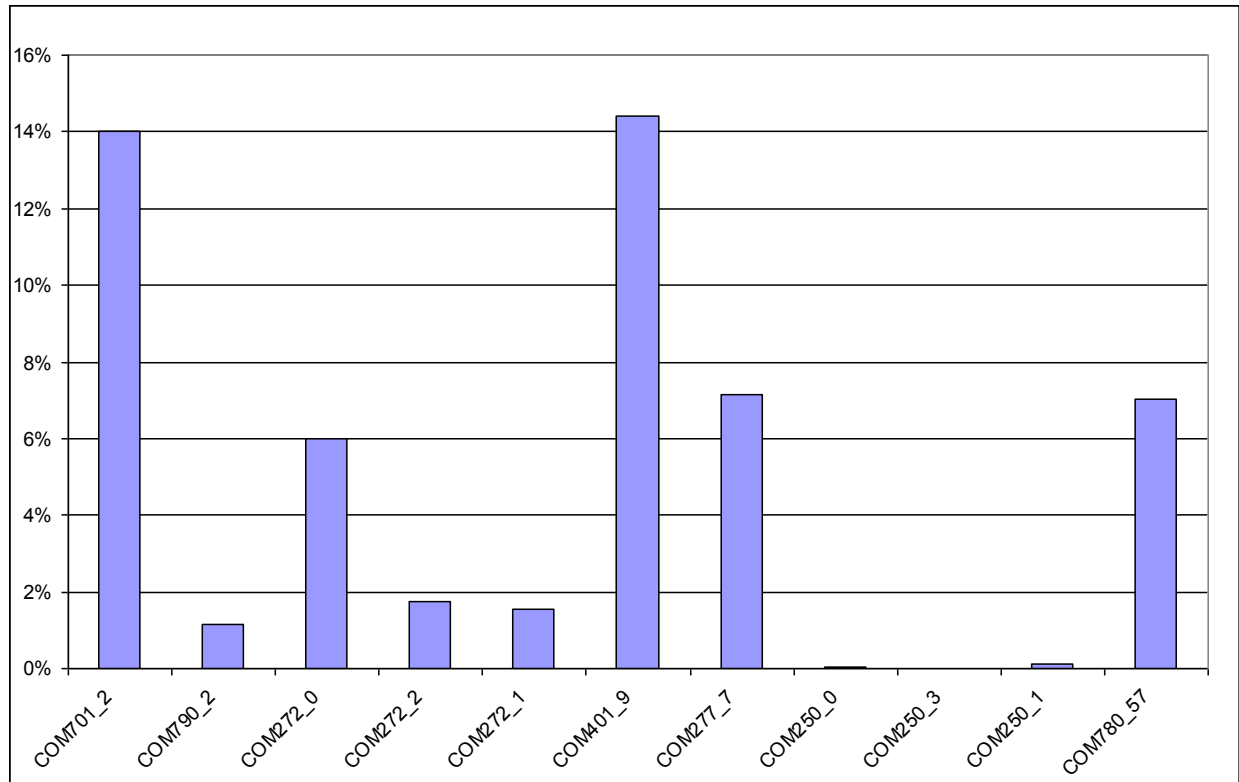
82947	Glucose, quantitative, blood
82948	Glucose, blood, reagent strip
83525	Insulin
80061	Lipid Panel
80076	Liver Panel
80048	BMP (Basic Metabolic Panel)

Diagnosis of Co-Morbidities Related to Obesity

This measure demonstrates the percent of participants diagnosed with obesity who also had a diagnosed co-morbidity. This is based upon all participants diagnosed with obesity. It is the goal of the program to increase the Primary Care Provider's awareness of the co-morbidities associated with obesity and the impact at early ages.
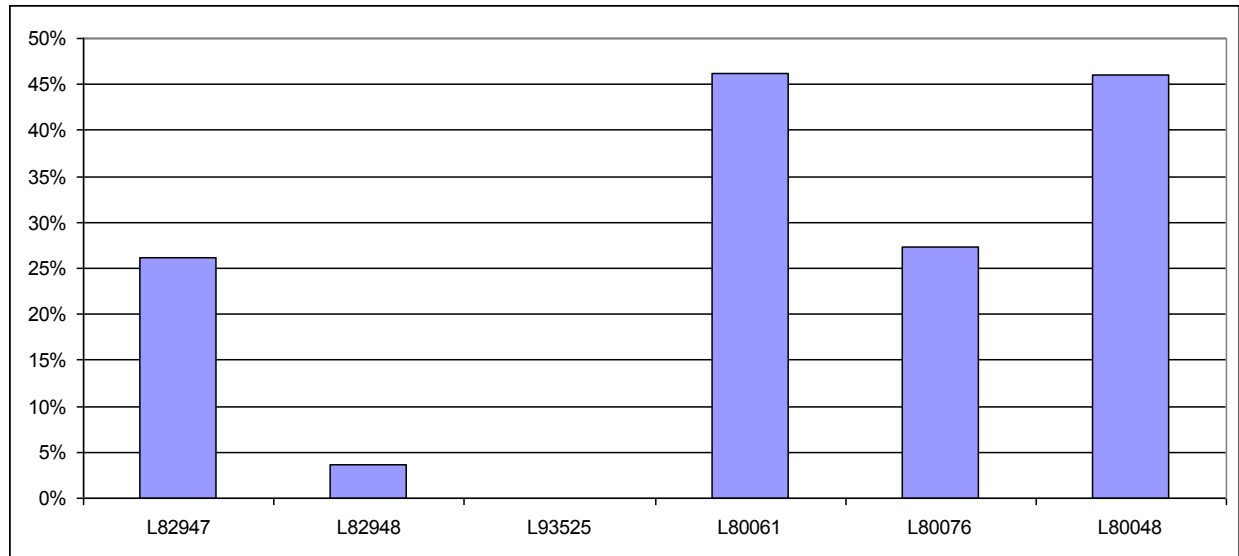
701.2	Acanthosis Nigricans
790.2	Abnormal Glucose Tolerance Test
272.0	Pure Hypercholesterolemia
272.2	Mixed Hypercholesterolemia
272.1	Hypertriglycerdemia
401.9	Hypertension
277.7	Dysemetabolic Syndrome
250.0	Type II DM, Controlled
250.3	Type II, DM, Uncontrolled
250.1	Hypoglycemia Related to Hyperinsulinemia
780.57	Sleep Apnea

Mental Health Care Management including Case Management

New Directions Behavioral Health Care Management including Case Management
Ambulatory Care for Behavioral Health
In 2004, New Directions began the Personal Transition Service (PTS) Program, which provides one in-home intervention from a licensed behavioral health practitioner within 72 hours of discharge from the hospital. New Directions has contracts with
local clinicians to provide in-home therapy. These services involve a one-time follow-up post-hospital visit. While visits typically take place in the member's home, an office visit option is offered.

The assigned New Directions care coordinator screens each member receiving inpatient care management for referral to a licensed PTS Clinician. Based on the results of the screening, a PTS appointment is scheduled within 7 days of discharge. During the individual session, the PTS clinician:

   1. Reviews medications prescribed and medication adherence.

2. Ascertains that follow-up visits have been scheduled.
3. Develops an individualized safety plan.
4. Coordinates with New Directions staff if an urgent appointment is needed.

This program was presented at the 2005 *NCQA HEDIS® Update and Best Practices Conference* and showed statistically significant change in HEDIS® ambulatory follow-up scores from FY2003 to FY2004. Lisa Woodring and New Directions' Chief Clinical Officer presented "Improving Patient Safety," a presentation that combined our Ambulatory Follow-up Program (including PTS) and Physician Notification Program. Below is a description of the results for CMFHP discharge, including the effects of the PTS program on ambulatory discharge.

In 2007 when the contract with New Directions began, 414 CMFHP members were discharged from inpatient care, not including those that stepped down to sub-acute or residential care.

- 341 members (82 percent) followed up within seven days
- 69 members (17 percent) had follow up appointments after seven days
- 12 members (3 percent) discharged to OON provider, C Star program, or refused
- 7 members (2 percent) discharged without follow up appointments

The following chart shows ambulatory results:

Ambulatory Follow-up

Legend:
- Follow-up in 7 days
- Follow-up after 7 days
- OON, C-Star, Refused
- No Follow-up
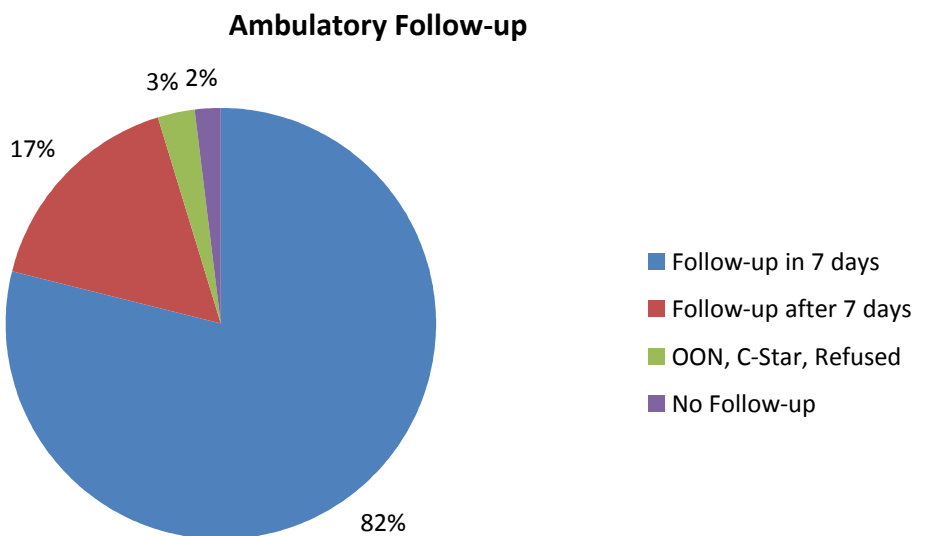
The New Directions Care Management Team tracks and trends the post-discharge care received by the remaining 18 percent of members. Many members discharge to C-Star programs and/or out-of-network services because they receive intervention from DFS, DMH, or the legal system. New Directions continues to analyze barriers to ambulatory follow-up.

Of those receiving ambulatory follow-up in 7 days, New Directions provided services, with 14% of these members receiving a PTS intervention, as follows:

Percentage of Members Using PTS Services
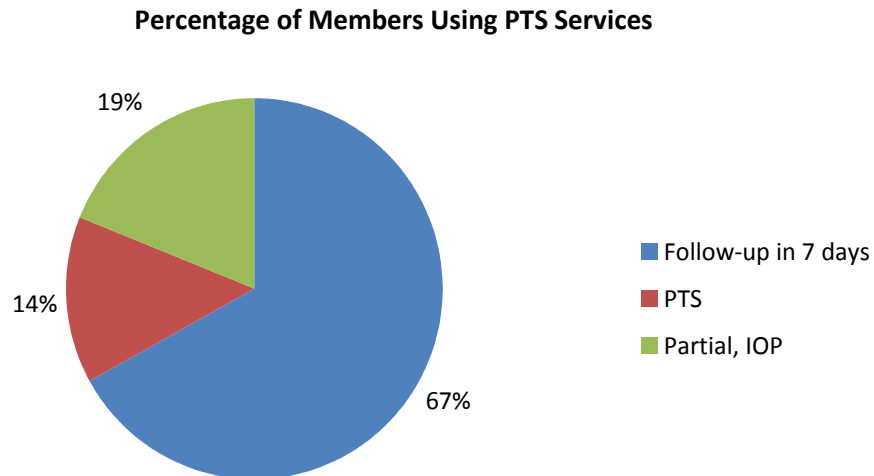
Family Evaluation/Therapy for Adolescent/Child Members
Behavioral Health

New Directions offers CMFHP members the Parents and Children Together (PACT) program, which contributes to improved behavioral health by providing intensive, in-home care and case management. A small group of affiliate clinicians that also
do in-home therapy have been credentialed to address geographical limitations of the PACT program. The goals of this program include:

1. Intervention with the family system.
2. Sustained medication adherence as needed.
3. Appropriate monitoring of symptoms and changes in the family context.
4. Motivation for treatment and self-care among individuals at risk for relapse.

The typical case for in-home therapy involves a youth with a behavioral health disorder, compounded by multiple family problems. The behavioral health pathology may lead to the youth's refusal to cooperate with outpatient treatment recommendations. This may lead to an acute episode of the behavioral health problem. Aggressive behaviors and anger outbursts are not unusual. Families have financial limitations and may not have easy access to transportation.

The need for a more intensive level of care increases when the family cannot follow outpatient recommendations. Often, in-home intensive family therapy is used to avert a crisis situation. In other cases, residential or inpatient care has already been provided, and the in-home therapist is asked to provide ongoing care.

When the therapist can go into the home, the family is not burdened to find transportation and get the youth to the appointment. Once in the home, the therapist can intervene in an environment that promotes more ─natural" behaviors than those seen in a professional office. This type of intervention, which is both intense and based on ─teachable" situations, is effective in preventing crises, relapse, and readmissions.

New Directions contracted with two facilities in 2008 to offer up to 72 hours of respite care services for children and adolescents during times of crisis. During respite, in-home therapy is introduced and the crisis averted.

In some cases, New Directions calls on our clinicians who provide in-home therapy to intervene with adults. In one recent case, a woman with diabetes and heart disease was admitted with a medication overdose due to depression and anxiety. An in-home therapist helped by providing emotional support and encouragement to follow medical advice. Coordination of care occurred between all providers involved. As a result, a readmission for psychiatric inpatient hospitalization was avoided.

In some instances, the in-home clinicians find a need for urgent services during a home visit. The clinician then contacts New Directions for immediate assistance, often averting an emerging crisis.

In 2007, 126 CMFHP Members benefitted from in home services.

Medical-Surgical/Behavioral Health Integration

New Directions has developed innovative approaches to integrate behavioral health and medical/surgical treatment for members. In this way, each person's physical, psychological, and social needs can receive coordinated care. The behavioral health provider must complete a focused screening and advise members to see their Primary Care Physician (PCP) when concerns are identified. The MHCMs actively coordinate with the health plan on cases involving comorbidity.

Communication with Primary Care Physicians

Unless the member declines to sign a release of information, behavioral health providers must communicate with the PCP. This ensures that PCPs receive information regarding behavioral health care. This information helps PCPs avoid medication duplication and incompatibility, and also alerts the PCP to the behavioral health needs of the member.

New Directions contacts the PCP for coordination of care:

- At the time of admission for acute psychiatric inpatient care
- Any prescribing physician & PCP is also contacted when a member is hospitalized due to a overdose of prescribed medications
- If any concerns about prescribed medications and/or use of multiple providers occurs

Substance Abuse Services and CSTAR

CSTAR services have been —carved-out" of the MO HealthNet program and are reimbursed on a fee-for-service basis according to guidelines established by the Missouri Division of Alcohol and Drug Abuse. CSTAR serves pregnant women, women with children, adolescents and men eligible to receive MO HealthNet benefits. Services provided by a Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Provider are not the responsibility of the health plans providing MO HealthNet services. The health plan is responsible for inpatient detoxification services.

When appropriate, individuals seeking substance abuse services are referred to CSTAR programs. When such services are not geographically accessible or if an individual chooses not to participate in a CSTAR program, New Directions will provide non-CSTAR substance abuse services.

When New Directions receives a CSTAR Notification of Care Activity Report indicating that a behavioral health need has been identified, the MHCM will coordinate the member's access to a mental health provider. New Directions also sends reminders to CSTAR Providers regarding the use of this form.

High-Risk Notification Form
To identify members needing intensive case management, providers must complete a High-risk checklist when they first see a member. This form is then faxed to New Directions' MHCMs, which initiate intensive case management of these members.

Members that have such complex needs often utilize high levels of both medical-surgical and mental health services. It is imperative that the care of these members be effectively coordinated. High-risk cases are reviewed at the weekly case management meetings with the New Directions Medical Director. The MHCM works in conjunction with all the providers and agencies that may be involved in a member's care to develop an effective, proactive treatment plan.

Special Health Care Needs Children
The state designates children with special needs, including but not limited to:

- Children with physical and mental illness;
- Foster care children;
- Children who are seriously and emotionally disturbed (SED) and/or have substance abuse problems;
- Children who are disabled; and
- Chronically ill children with developmental or physical disabilities

Although some of these children are not in eligibility categories that fall within the responsibility of New Directions, many are. Most eligible children are identified by the use of the High-Risk Notification Form and placed in intensive case management. New Directions also works closely with health plan Care Managers to assist in care planning for special needs children.

Intensive Case Management

New Directions began this initiative by putting together a committee of inpatient and outpatient providers, Community Mental Health Centers, and managed care company representatives. The committee identified trends and triggers of clients that frequently readmit. Based on those triggers and trends, actions were developed that were placed into action and showed positive results. Collaboration with providers was initiated to improve communication and average length of stay. Attached graphs show an overall decrease in readmissions. New Directions' Intensive Case Management (ICM) program has grown from a small committee, into a large, fully self-sustaining case management program. The ICM offers intensive levels of in-home and in-office therapeutic services to clients in the greatest need and at greatest risk of requiring higher levels of care. ICM members have access to their therapist until late in the evening and even have access by non-typical routes such as email and telephone. The ICM therapists are highly motivated to maintain these members in the lowest level of care that is clinically safe and appropriate. Use of this program has saved countless members from needing to be locked in a psychiatric unit, by deescalating volatile situations prior to them becoming out of control and also by teaching parents and guardians more effective coping skills to avoid escalation.

Clinical Practice Guidelines

Clinical practice guidelines are an integral component of Children's Mercy Family Health Partners (CMFHP) utilization management and disease management programs. CMFHP distributes clinical practice guidelines to physicians as requested. Milliman Care Guidelines are the primary resource utilized by the Pre-certification, Utilization Review, and Care Management nurses for medical necessity determination of requested services or procedures.

In addition to Milliman Care Guidelines, clinical practice guidelines are developed internally by CMFHP Medical Directors and Health Services management staff, utilizing available nationally recognized resources. All clinical practice guidelines utilized or distributed by CMFHP are reviewed through the Clinical Criteria Committee, with oversight by the Health Services Review Committee prior to implementation.

In addition, CMFHP distributes immunization and preventive guidelines annually to all network providers. These guidelines are adopted from nationally recognized sources and represent evidence-based practice standards. CMFHP maintains a policy on the adoption and distribution of clinical practice guidelines.

Credentialing and Re-Credentialing

Children's Mercy Family Health Partners completes all credentialing and re-credentialing in house, which includes the oversight of all delegated entities through an annual review according to NCQA Standards. The credentialing and re-credentialing process includes review of the application for completeness and any additional information that may be necessary based on responses to specific questions and primary source verification, as well as Medicare/MO HealthNet sanctions. Children's Mercy Family Health Partners subscribes to the NCQA guidelines for credentialing/recredentialing practices.

Overall in 2008, Children's Mercy Family Health Partners credentialed 164 new Missouri providers and completed re-credentialing of 162 Missouri providers. We also completed the

annual review of our delegated entities. Of our delegated groups, all were at 100 percent compliance with meeting all standards. Our delegated groups are University Physicians Associated, Bridgeport, Children's Mercy Hospital and Physicians as well as New Directions and HealthFirst.

Children's Mercy Family Health Partners continues to successfully credential and re-credential providers and facilities as well as complete delegated audits in a timely manner.

Medical Record Review
Children's Mercy Family Health Partners (CMFHP) maintains a provider network for delivery of coordinated quality medical care to members. CMFHP performs medical record reviews every three years based on the NCQA Credentialing and Re-credentialing schedule.

Since 1997, Children's Mercy Family Health Partners has coordinated a comprehensive medical record review of the Primary Care Providers' health care delivery to members similar to those described in the Request for Proposal. CMFHP uses analysis of Primary Care Provider Medical Record Reviews as a mechanism to identify areas for improvement opportunities. Medical record review performance indicators are grouped by category and prioritized. Actions are then developed to improve provision of services to members and improve provider documentation of services.

In the reporting period July 1, 2007 through June 30, 2008, no issues emerged as not meeting thresholds consistently for Medical Record Indicators. In addition, the issues identified as not meeting threshold for Clinical Quality Indicators were lead related activities and testing. CMFHP had a Performance Improvement Project (PIP) for lead screening and testing that has demonstrated statistically significant improvements in lead screening rates. CMFHP incorporated ongoing lead screening outreach activities as a result of the PIP outcomes. Other Clinical Quality Indicators not meeting threshold during the reporting period are mammogram screenings, asthma action plans within the medical record and adult immunization records. CMFHP incorporated mammogram screening reminder mailings into its outreach activities biannually. CMFHP has an Asthma Disease Management Program that provides education to providers regarding asthma action plans. Providers not meeting threshold are given education in the closing of the review and referred to the asthma educators. CMFHP continues ongoing education to providers regarding documentation of adult immunizations.

To address ongoing quality improvement activities, support the success of previous findings and continue to maintain and improve documentation standards in member records, CMFHP continued provider education in this reporting period through the Medical Record Review Education and Provider Newsletters. Provider Newsletters were sent in September 2007, November 2007, April 2008 and May 2008.

The tables that follow demonstrate the tracking and trending of clinical and medical record maintenance indicators for the reporting period and comparisons with previous years.

Primary Care Provider Medical Record Reviews

		FHP	FHP	FHP	FHP	FHP	FHP	FHP	FHP

	Target	2008	2007	2006	2005	2004	2003	2002	2001
# of Practices/Groups assessed/reviewed		23	44	46	36	17	24	64	*
# of PCPs assessed/reviewed		80	71	148	42	36	69	185	40
# of Member Records assessed/reviewed		484	1083	1642	801	489	689	1841	408
CLINICAL INDICATORS	**Target**								
Are risk factors for disease identified?	90%	100%	100%	100%	100%	100%	98%	90%	99%
Is family and personal (past medical history) documented?	90%	100%	100%	100%	99%	99%	97%	91%	99%
Is there identification of smoking?	90%	100%	100%	100%	99%	96%	98%	97%	83%
Has smoking cessation been discussed?	75%	100%	100%	99%	94%	87%	70%	81%	16%
Has the effects of passive smoking been discussed?	75%	100%	100%	99%	94%	87%	81%	83%	15%
Is there identification of alcohol use?	75%	100%	100%	100%	97%	95%	97%	97%	75%
Is there identification of illegal drug use?	75%	100%	100%	100%	94%	93%	97%	95%	73%
Has anticipatory guidance been discussed and/or given?	90%	99%	100%	100%	98%	100%	96%	83%	72%
Education regarding sexual activity?	60%	99%	100%	99%	94%	82%	95%	82%	77%
Age specific adult immunization record?	60%	28%	17%	24%	71%	68%	26%	24%	52%
Documentation of early diagnostic screens?	90%	99%	99%	100%	99%	100%	98%	86%	99%
Pap Smear (start when sexually active)	70%	79%	67%	73%	89%	80%	84%	76%	75%
Mammogram(start at age 40)	75%	53%	67%	75%	75%	57%	69%	63%	75%
Lead Questionnaire included in EPSDT screening?	100%	50%	78%	68%	78%	74%	65%	50%	46%
Blood Lead level for any positive response on the lead questionnaire?	100%	100%	100%	98%	92%	97%	81%	74%	74%
Blood level 12 months?	100%	61%	98%	78%	82%	82%	60%	56%	66%
Blood level 24 months?	100%	58%	100%	86%	77%	84%	53%	47%	67%
Blood levels for all children aged 12 – 72 months	100%	43%	59%	56%	56%	63%	52%	35%	89%
Dental referral documented?	57%	100%	100%	96%	95%	89%	92%	83%	52%
Documentation of a dental screen/exam?	57%	87%	86%	84%	88%	88%	88%	83%	79%

Documented height?	85%	98%	98%	99%	99%	97%	90%	87%	87%
Documented weight?	85%	100%	100%	99%	100%	100%	99%	100%	99%
Documented B/P? (start age 3)	85%	98%	99%	96%	98%	97%	96%	96%	95%

Clinical Quality Indicators (cont)	Target	FHP 2008	FHP 2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001
Documented history regarding exercise?	50%	100%	100%	100%	100%	94%	95%	86%	84%
Documented history regarding diet intake?	75%	100%	100%	100%	100%	96%	95%	87%	76%
Documented hearing test/screen? (1mo-20 years & at risk)	80%	93%	95%	92%	91%	91%	90%	81%	75%
Has an Asthma Action Plan been Initiated?	80%	97%	100%	99%	96%	84%	86%	55%	56%
Is there an Asthma Action Plan in the record?	80%	45%	97%	91%	95%	62%	62%	32%	44%
Has the member had an HbA1c once every 6 months?	50%	88%	92%	94%	100%	69%	86%	86%	*
Has the member had a foot exam with every office visit?	75%	64%	41%	73%	86%	60%	36%	50%	*
Has the member had an annual dilated eye exam?	75%	44%	54%	76%	100%	53%	36%	54%	*
Has the member had a yearly LDL?	50%	68%	95%	94%	100%	69%	64%	83%	*
Documented vision screens?(3-21 years screen-1-36 mos & at risk)	80%	92%	95%	90%	91%	90%	89%	79%	79%

Medical Record Maintenance Indicators	Target	FHP 2008	FHP 2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001
Are age appropriate EPSDTs documented?	80%	89%	91%	90%	90%	88%	88%	79%	88%
Is there an age specific pediatric immunization record?	90%	87%	90%	87%	97%	97%	89%	79%	79%
Presenting problems from previous office visits									

Question									
addressed in visits?	95%	100%	100%	100%	100%	100%	100%	98%	100%
Are unresolved problems from previous office visits addressed in visits?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Is there documentation of an action/treatment?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Does record indicate follow up dates to treatment?	95%	100%	100%	99%	100%	100%	100%	99%	99%
Do all pages contain patient ID?	95%	100%	100%	100%	100%	100%	100%	96%	99%
Is documenting person signing, initialing progress/treatment notes?	95%	100%	100%	100%	100%	100%	100%	100%	100%
Are all entries dated?	95%	100%	100%	100%	100%	100%	100%	100%	99%
Is the record legible?	95%	100%	100%	100%	100%	97%	100%	100%	100%
Is there a problem list?(Member seen 3 times or more)	95%	80%	87%	82%	100%	81%	70%	72%	96%
Are allergies and adverse reactions to medication prominently displayed?	95%	99%	100%	100%	98%	85%	97%	98%	99%
Is there a referral/correspondence note related to state(s) of health?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Is education related to medication documented?	95%	100%	100%	100%	100%	100%	93%	99%	92%
Are diagnostic test results initialed or in plan of care?	95%	100%	100%	100%	100%	99%	99%	99%	97%
Is follow up for hospitalization requested by the provider?	95%	100%	100%	100%	100%	98%	99%	98%	93%
Is urgent/ER service follow up requested by the provider?	95%	100%	100%	100%	100%	97%	100%	97%	99%
Does the DOS & ICD9 code match documentation in medical record?	100%	99%	100%	97%	*	*	*	*	*

					*	*	*	*	*
Does the DOS & CPT code match documentation in medical record?	100%	100%	100%	99%					

* Indicator not applicable

Children's Mercy Family Health Partners continues to monitor the outcomes of these medical record reviews to identify additional initiatives that will result in furthering the improvement trends.

Subcontractor Monitoring

Bridgeport Dental Services

Children's Mercy Family Health Partners (CMFHP) subcontracts dental services from Bridgeport Dental. As part of our ongoing relationship with Bridgeport, we work with the entity to ensure dental access for members as well as to resolve issues that may arise in the areas of access, quality or member benefits.

A quarterly meeting between Bridgeport staff and CMFHP staff is held. During these meetings, a review of the quarter's grievances and appeals is done and issues and/or trends are identified. Further, performance projects and measures concerning Bridgeport are discussed quarterly and documented in CMFHP minutes. Areas that are always considered for performance projects and measures are community outreach activities as well as access for members to general dentists.

Bridgeport conducted recruitment efforts for the expansion counties in Western Region during 2007. Effective January 1, 2008, Bridgeport had a network in place to service the new MO HealthNet membership. Bridgeport has worked diligently on the Smile Central program. The Smile Central program contains educational pieces and an interactive website to promote oral health.

CMFHP and Bridgeport have collaborated on a MO HealthNet PIP focusing on children ages 4 – 10 in Jackson and Clay County who have not had a dental visit in the last 6 months. 15,000 postcards were mailed. Reported outcomes are expected in January 2009.

During Fiscal Year 2008, CMFHP continually monitored the encounter submissions and acceptance rates for Bridgeport. CMFHP continually works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. Bridgeport's monthly accepted rate for Fiscal Year 2008 has consistently been around 99%.

Bridgeport is proactive in identifying issues to CMFHP and has shown true integration with CMFHP and our Quality Management program to ensure that our members receive the best dental services possible in a timely manner.

New Directions Behavioral Health

Children's Mercy Family Health Partners (CMFHP) understands that coordinating behavioral health services with the rest of a member's health needs is essential in order to provide effective care. Since February 1, 2007, CMFHP has contracted with New Directions Behavioral Health to deliver behavioral health services to CMFHP members. Representatives from CMFHP and

NDBH met on a quarterly basis to review operational issues, monitor quality and utilization, and develop protocols to integrate medical and mental health services. NDBH provided comprehensive reports to the quarterly oversight meetings which included information about appointment availability, utilization trends, grievance trends analysis, and ambulatory follow-up after hospitalization.

In addition to the quarterly oversight meetings, the clinical management team for NDBH attended case rounds with CMFHP Care Managers quarterly to discuss cases where behavioral health issues were involved. This collaboration could occur on a daily basis, if needed, to coordinate care for members needing both medical and behavioral health services.

A project initiated by NDBH in 2007, the RE-Aim Project is designed to reach into the community to educate a range of providers and advocates that may be interacting with CMFHP members. Some completed interventions included meetings with the following agencies/organizations: Baby and Child Pediatric Group, School Nurse Conference, Center School District, Healthy Steps, Tri County Mental Health, Kaw Valley Center, and Truman Medical Center OP Program. The goal is to increase education about the types of services and benefits provided by NDBH.

CMFHP's Chief Clinical Officer and Director of Provider Relations maintained oversight of all of delegated activities, such as utilization management and credentialing. NDBH maintained URAC certification as a Utilization Review organization. NDBH also maintained NCQA accreditation for their credentialing processes. The Chief Clinical Officer performed an annual case management audit of NDBH records. The results of this audit were reported to the CMFHP Health Services Review Committee and the Medical Management Committee.

During FY 2008, CMFHP continually monitored the encounter submissions and acceptance rates for NDBH. CMFHP continually works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. New Directions' average accepted rate for FY 2008 is approximately 96%.

MTM and LogistiCare Transportation Services
Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available and manageable non emergent medical transportation. Beginning July 1, 2007 CMFHP contracted with Medical Transportation Management (MTM) to provide these services. From January 1, 2007 to June 30, 2007, CMFHP contracted with LogistiCare for these services, but switched to MTM due to performance issues. CMFHP had seen member grievances increase under LogistiCare's service, but since the change to MTM, member grievances have declined significantly.

Representatives from CMFHP and MTM met on a quarterly basis in FY 2008 to review operational issues, monitor quality and utilization, and develop protocols to provide high quality transportation services to CMFHP members.

The following enhancements/changes were made to the transportation program in FY 2008:
1. Increased gas reimbursement to .30/mile.

2. A newsletter article was sent to members to encourage use of transportation.
3. MTM presented to the CMFHP Community Advisory Council in an effort to spread the word about the transportation benefit.
4. New transportation brochures were developed to assist in member education.
5. MTM contracted with a courier in the KC metro area to deliver bus passes to those that meet criteria to ride the bus and call for transportation less than 48 hours prior to their appointments.

During FY 2008, CMFHP continually monitored the encounter submissions and acceptance rates for MTM. CMFHP continually works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. MTM's average accepted rate for July 1, 2007 to June 30, 2008 is approximately 94%.

An action plan was developed for both vendors and issues were tracked. This action plan continues to be a working tool to track issues and resolutions. CMFHP has submitted a 2007 non-clinical Performance Improvement Project (PIP) designed toward improving non-emergent transportation services to members. The following hypotheses were submitted:

> ―By developing an operational action plan and conducting more frequent oversight visits with the transportation vendor, access to transportation services will increase and member grievances related to transportation services will decrease."

Results of this PIP are available in a separate section of this Annual Appraisal.

Sentinel Events
Children's Mercy Family Health Partners has functionally defined sentinel event(s) as a case(s) of an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ―or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. There were unexpected deaths and injuries, but upon medical review, none appeared to be outside the standard of care. Sentinel events, a patient safety indicator, will continue to be reviewed and analyzed as they occur during 2008.

<center>**Harmony Health Plan of Missouri**</center>

Provider Satisfaction
Harmony/WellCare implemented two new provider survey vehicles over the last year.
The first was to standardize the provider survey questionnaire across the majority of WellCare products. WellCare's intent was to apply consistent metrics to the data obtained from the surveys in order to identify best practices and/or systemic issues Corporate-wide. The second was a telephonic survey, implemented in all WellCare markets and introduced early this year in our Missouri market. This telephonic survey is activated when a provider calls our Provider Service Center. Prior to being connected to a customer service agent, the provider is prompted to choose if they would like to participate in an anonymous survey following their call. Once the provider selects the yes or no prompt their call is routed to the customer service agent as normal.

If the provider chose to participate in the survey, upon termination of their call with our customer service agent, the provider would receive an almost immediate call-back which is the automated survey consisting of approximately five questions.

While both of these survey vehicles have been successful in many of our other markets, we have found the response from our Missouri providers so low they are not statistically relevant. Because of this low level of participation, we have identified the following actions:

Harmony will return to our initial protocol of mailing the attached letter and survey to our participating Missouri providers from our regional office. This mailing was planned for fall; however, at the states request we can move-up our mailing date to as early as August 15th.

We will continue to offer the telephonic survey prompt, and have established a committee to identify opportunities to promote the survey among our providers.

Care Coordination
(EMMA) CASE AND DISEASE MANAGEMENT INFORMATION SYSTEMS
WellCare maintains a health information system Enterprise Medical Management Application (EMMA) that collects, analyzes and integrates the data necessary to implement its quality Case and Disease Management programs. In addition, the information entered into the system is reliable, complete and secure, providing the department with high quality reporting capabilities. The system provides the Case Manager with automated prompts for Member follow-up and Care Plan intervention implementation. Recorded actions or interactions with the Member assist in providing a clear vision of the Member's needs, goals, interventions and outcomes.

EMMA is transparent, allowing for a comprehensive unobstructed view of the Member across all WellCare departments from Intake to Appeals. Member privacy for Private Health Information (PHI) and HIPAA compliance is ensured with security level access assigned on a _need to know' basis for employees across company departments.

EMMA Overview
Key Benefits:
• Facilitates integrated Care, Case, Disease and Utilization Management
• Provides foundation for increasing the % of members under case management
• Provides better targeting and management of members with greatest needs, and improves outcome quality
• Improves efficiency by consolidating multiple systems into a single system and increasing automation
• Improves member and provider satisfaction through better consistency of service
• Allows WellCare to implement new programs and efficiently enter new markets

Importance:
Compliance
• Automation of key business processes and workflows provides consistent delivery and contract compliance
• Validation rules and data edits improves accuracy

- Standardization of Health Services letter generation and tracking drives enterprise compliance

Business Reliability
- Reduced number of systems drives less points of failure and errors
- Improved and consolidated business rules reduces data entry errors

Cost Containment
- Automated workflows and decision making drives productivity
- Consolidated functions and member data into a single system reduces support costs and increases efficiencies for Health Services

Growth
- Single enterprise system improves time to market delivery for Long Term Care opportunities (e.g. Hawaii)
- Automated systems platform positions WellCare as a technology leader

Member Impact – Testimonial
From Tana Le Roux, PMP, EMMA Project Manager, WellCare Health Services

Friday, 8/8/2008

I wanted to share something with you all.

While speaking to a Behavioral Health Case Manager this morning, she told me how excited she was to be using EMMA. Recently, there was a case with a member who had a variety of medical problems. A recommendation was made to Behavioral Health because of the member's depression secondary to the tragic loss of her son. Case Management and Behavioral Health both served this member. Now, the woman has been transferred to Disease Management because of long-term health issues that have been identified. The Case Manager was thrilled that she was able to see the ―whole picture" of this member's problems and recommend her for the service she needed and deserved. Not until EMMA could she provide this integrated level of care.

If we make a difference in one member's life – these long hours and frustrations are all worth it.

Folks – we have made a difference."

Case Management
Overview
Harmony is able to offer individualized services that provide coordination of care, education, resources in our member's community, and the promotion of good health throughout our membership by ensuring appropriate access to care.

Harmony's Case Managers utilize a member centric approach to care; taking into account the member's medical, social, and behavioral health needs.

Harmony offers individualized case management services that provide coordination of care, education, resources in our Member's community, and the promotion of good health throughout our Membership. Case Management further *integrates* the essential services of behavioral health case management, and pharmacy to provide a complete Member centric approach to service facilitation, delivery and coordination of care that meets the Members' needs in a holistic manner; taking into account the Member's medical, social, and emotional needs.

Harmony's Philosophy of Case Management is based on the integration of three disciplines to provide a Member centric approach. Harmony's integration of medical case management and medical disease management, behavioral health case management, and pharmacy provides added value to the Member. This integration fosters collaboration between the three disciplines/ departments therefore, providing the Member with unparallel continuity of care and care coordination. This continuity extends throughout the continuum of life, on all medical or psychosocial needs from birth to end of life.

The three disciplines combine to provide the Member with traditional *Case Management benefits* (coordination of care with providers), *behavioral health benefits* (mental health issues, substance use) and *pharmacy benefits* (consults with a pharmacist for Members to better understand medications and medication interactions). The three disciplines work collaboratively to meet the highly complex medical and psychosocial needs of our Members.

Purpose
The purpose of the Case Management Program is to provide medical, behavioral, and socioeconomic assistance to Members by facilitating coordination of care, service delivery, determination of benefits and community resources, and education. Case Management ensures continuity of care, transition of care, and all Member needs in an integrated fashion that is Member centric.

Goals
The goals of the Case Management Program are:
- To identify eligible Members for Case Management Services.
- To provide Members assistance with coordination of care.
- To identify barriers to care and develop solutions to those barriers
- To ensure access to quality care.
- To ensure service delivery and high quality care.
- To maximize Members' independence related to their condition and needs.

Objectives
The objectives of the Case Management Program are to:
- Implement coordination of care for medically and behaviorally complex Members.
- Conduct a comprehensive assessment and develop a Care Plan with established goals, time frames for reevaluation, resources, interventions and outcomes.

- Provide appropriate referrals as needed i.e. behavioral health, pharmacy, disease management, etc.
- Direct Members in the Case Management Program to needed care and access to services.
- Ensure a smooth transition of care for Members with complex conditions.

Program Description
Case Management strives to meet the needs of the medically frail population with a model that focuses on the Member's complex medical, socioeconomic and behavioral health needs. The Case Managers assists the Member to achieve their highest individual level of wellness and ability to function independently.

Harmony recognizes that this special population has extremely complex socioeconomic, and health needs. Harmony's approach is effective because the Member remains the focal point of all three disciplines. Harmony has combined the components of Medical Case Management programs, Disease Management programs, Behavioral Case Management programs and Pharmacy. The Case Management Integration diagram illustrates the synergy between disciplines medical, behavioral, and pharmacy.

CM Integration
This diagram depicts, where these three disciplines/departments intersect is where MO HealthNet's Case and Disease Management program is formed. This synergistic opportunity is where all the greatest talents of the three disciplines come together to form our seamless, multi-faceted program.
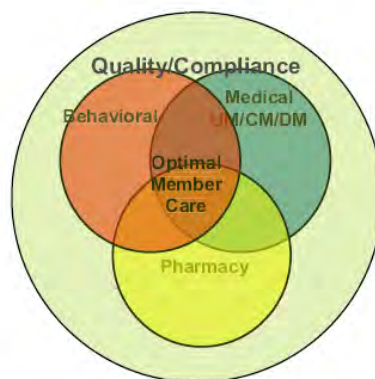
Case Management Process
The Case Management process illustrates the formation of one seamless Case Management Program and begins with Member identification, and follows the Member until discharge. Harmony's philosophy is that these programs are an integral management tool in providing a continuum of care for our Members. The Case Management process is as follows:
- Member Identification
- Member Stratification
- Member Evaluation
- Member Planning

- Member Service Facilitation
- Member Advocacy

Member Identification

Harmony's integrated philosophy is the foundation of all components of the program, beginning with Member identification. Harmony utilizes traditional reactive methods of identifying members for inclusion into its Case Management. These methods include but are not limited to:

- 24/7 nurse information line referral
- Medical and Behavior Health Disease Management Program referral
- Pharmacy referral
- Medical and Behavior Health Case Management Program referral
- Hospital Discharge Planner referral
- Utilization Management Program referral and Utilization Management process
- Intake Coordinator referral
- Concurrent Review Nurse referral
- Member self-referral
- Provider/Practitioner referral

Additionally, on a monthly basis, Harmony uses more proactive methods to identify Members potentially needing Case Management services. This is accomplished by running proprietary algorithms against claims data from:

- Pharmaceutical, point of sale;
- Medical/professional services; and
- Institutional services

From these algorithms, Harmony biostatisticians are able to establish a cohort of Members identified as those at the highest risk for poor outcomes and increased utilization of services.

Member Access to Case Management

Harmony Members have access to Case Management at any time. The Member can self refer or receive referral by a provider to the program (s) utilizing:

- Health information line referral;
- 24 hour nursing line; or
- Case Management toll free line, TTY/TTD available in unit.

Harmony's Case Management programs are ―opt out" programs. Members identified as candidates for the program are categorically enrolled. The Member must actively seek disenrollment to be excluded from services. This enrollment methodology ensures that all potentially qualified Members receive services without having to seek Case Management services.

Case Management Information Systems

Harmony maintains a health information system Enterprise Medical Management Application (EMMA) that collects, analyzes and integrates the data necessary to implement its quality Case Management Program. In addition, the information entered into the system is reliable, complete and secure, providing the department with high quality reporting capabilities.

The system provides the Case Manager with automated prompts for Member follow-up and Care Plan intervention implementation. Recorded actions or interactions with the Member assist in providing a clear vision of the Member's needs, goals, interventions and outcomes.

EMMA is transparent, allowing for a comprehensive unobstructed view of the Member across all Harmony departments from Intake to Appeals. Member privacy for Private Health Information (PHI) and HIPAA compliance is ensured with security level access assigned on a ‗need to know' basis.

Member Stratification
Once the proprietary algorithms are utilized to identify eligible Case Management run, the results are run through additional algorithms to stratify the Members into a three tiered system:

> High Risk – Members receive Case Management services.
> Moderate Risk – Members receive Disease Management services.
> Low Risk – Members receive quarterly mailings of newsletters and campaign mailings, i.e., mammogram screening reminders in October, healthy heart reminders during the month of February, etc.

The validity of the data and stratifications is confirmed by direct assessment of the Member. This process begins with those Members reached receiving a Mini-assessment (health risk assessment) by a Case Management Coordinator. The para-professional conducting this assessment is able to ascertain at the conclusion to the assessment whether the Member is appropriately served by a Case Manager.

The Mini-assessment is conducted on all Members who have been reached and are willing to participate in the Case Management Programs. The Mini-assessment is not a comprehensive evaluation of the Member but it contains some very powerful screening tools. The Mini-screening includes:

- Patient Health Questionnaire (PHQ-9) – The PHQ-9 is a screening tool used to determine a Member's depression status. All telephonically screened Members are asked the first two questions of the PHQ-9. If a Member tests positive for this screening, they immediately qualify to be ―warm transferred" to an RN Case or Disease Manager for completion of the PHQ-9. If the Member tests positive in this screening (score of 15 – moderate depression or higher), a warm transfer to a Master in Social Work (MSW) Case Manager or a Behavioral Health (BH) specialist. If the Member is not immediately transferred to BH, the Member is scheduled for a comprehensive assessment with an MSW Case Manager who conducts the assessment with an end goal of creating a comprehensive Case and/or Disease Management Care Plan.

- CAGE/CAGE-AID - The CAGE (alcohol) and CAGE-Aid (drug) are four questions that have been shown to effectively identify Members who may have a problem with substance use. Each affirmative response earns one point. One point indicates a possible problem, which warrants a dialogue with the Member to suggest a referral to a Behavioral Health provider for an evaluation. Two points indicate a probable problem and is the threshold for referring to a BH Specialist.

- Short Form (SF-8) – A standardized tool to establish a baseline and measure over time the Member's perception of wellness.

Member Evaluation
Members that meet criteria for admission into our Case Management Program are scheduled for a comprehensive assessment with an MSW or RN Case Manager. The Members are provided with program information after entering the Case Management Program i.e. written program information describing available services, correspondence (Welcome Letter), company website information, educational information, etc. The Members are informed on the option to "opt out" or not participate in the program (s).

The comprehensive assessment is meant to:
- Identify the Member's health status and condition specific issues, including comorbidities;
- Provide documentation of historical medical information including medications, key events related to condition, hospitalizations, etc.;
- Identify needs (medical, behavioral, social), barriers, and assess activities of daily living and need for assistance;
- Identify cultural and linguistic preferences or limitations and provide assistance as needed. These include a language line, bilingual website, multi-lingual telephone prompts and educational literature;
- Provide inclusion of mental health status, social and economic assessment, cognitive functions and life planning (advanced directives, living wills, power of attorney, etc);
- Determine the Member's knowledge base, willingness or ability to adhere to the prescribed treatment regime; and
- Gather the information to create a Care Plan with short term and long term goals, interventions, follow-up, and outcomes.

Once in the Case Management Program, Members are contacted on an as needed basis to provide high quality coordination of care and education. This can be multiple times in a day or at least on a monthly basis. This is part of the Care Plan that is developed during the comprehensive assessment.

Harmony's Case Management Program consists of six categories:
- Catastrophic – head injury, near drowning, burns, etc.
- Complex – multiple comorbidities or multiple intricate barriers to quality health care.
- Pre Natal – All Members reached receive an initial assessment to determine the level of risk. Those found to be lower risk receive departmental contact information and are encouraged to outreach to the prenatal program as necessary. Those found to be high risk are inducted into:

- High Risk Obstetrics Program – teen pregnancy, past history of low birth weight, history of pre-term birth, etc.
- Transplantation – organ failure, donor matching, post-transplant follow-up.
- Special Needs Population – developmentally delayed, autism, failure to thrive, etc.
- Long Term Care – medically frail elderly.

Member Planning

Upon completion of the comprehensive assessment, the Care Plan is developed with the information obtained during the assessment. Harmony's Case Managers utilize the Care Plan as the guiding document for the Member's needs. A schedule for follow-up is system generated to ensure compliance with the established goals in the Care Plan, and to assure the appropriate time frame for reevaluation. Member planning also includes the need for continued care and addresses issues related to the transition of care or transfers. The Care Plan is viewed as a fluid document that continually drives the Member's care.

Vital to the services provided for the Member, the Care Plan is developed based on nationally recognized standards of care (ADA, APA, etc.) and utilizing evidence based guidelines. The Case Manager is responsible for creating a Care Plan with the Member, and collaborates with the caregiver, the PCP, and/ or Specialist who are instrumental participants in the development of the Care Plan. The Member is encouraged to self manage their signs and symptoms, activities, weight, blood pressure and glucose levels. If the Member is incapacitated and unable to participate in the actual planning process, the caregiver, or individual responsible for the care of the Member is encouraged to become involved in the planning process.

The Care Plan includes goals and interventions for the Member, as well as information pertaining to Hospice care, pain and palliative care, and end of life care. Upon completing the assessment the Case Manager shares the Care Plan with the Member, treating provider, (PCP, Specialist, and Behavioral Health Provider) and caregiver or individual responsible for the care. The PCP is informed on the available services Case Management offers through the provision of a Provider Manual, company website and disease specific brochures, etc. The Care Plan is sent to the PCP for signature and inclusion into the Member's medical record.

Re-Stratification

Upon completion of the Care Plan the Member is stratified once again within the current stratification level. This stratification is subjective and conducted by the Case Manager. This stratification is based on the gap analysis and health care service needs identified during the Comprehensive Assessment and Care Plan development. This stratification is based on four parameters:
1. Psychosocial, i.e., shelter, substance abuse, refusing care, etc.
2. Complex Medical Issues, i.e., Death/dying issues, ethics consult, complex discharge planning, etc.
3. External, i.e., complex transportation, community service needs, etc.
4. Internal, i.e., provider conference/education, long-term hospitalization, etc.

The results of this stratification place the Member into one of three levels of acuity:

Level 1: The Member is relatively stable in a disease process. These Members oftentimes need minimal assistance in scheduling their needed services. Service needs may be more psychosocial, i.e. housing, utility assistance, food, etc. Member is stable in self-care and needs episodic assistance.

Level 2 : The Member needs more assistance than a Level 1 Member. The Member may be a newly discharged or newly diagnosed Member, requiring greater support. Services that a Level 2 Member might receive are appointment scheduling for ongoing chemotherapy or radiation treatments, weekly contract to ensure adherence to treatment regime, depression counseling, appointment coordination and transportation arrangements for all services.

Level 3: The Member requires the most intensive Case Management services. This Member may need coordination, extensive training sessions with complex or multiple topics, scheduling and transportation to multiple providers, therapies, home health, home infusion, and/or complex durable medical equipment (DME) needs.

The Case Manager will make a referral to pharmacy services if the Member meets Medicine Therapy Management (MTM) criteria. Each Member is eligible for a comprehensive pharmaceutical assessment. Upon referral, a staff Pharmacist will review the Member's medication profile. The Pharmacist's primary focus is on toxicology and ensuring safety for the Member who may be confronted with poly pharmacy issues. If the Pharmacist determines special recommendations need to be made, the Member will telephonically receive information on their pharmaceutical needs. In addition, Pharmacy staff is available to resolve Drug Evaluation Review (DER) and benefit issues to facilitate the timely dispensing of necessary pharmaceuticals and assist the Member with over the counter (OTC) alternatives and guidance with frequency challenges. Pharmacy staff is also available for general medical education i.e. concerns, adherence, etc.

Member Service Facilitation
The Case Manager and Member contact is dynamic and ongoing for the duration of the Member's needs. The Case Management staff contacts the Member as necessary to manage the case. The Member's level of service is based upon the level of acuity as determined during the assessment and Care Plan development phase. The Care Plan is continuously updated to assess ongoing needs, progress, and/ or set new goals. The Member or individual responsible for the care of the Member has the ability to directly contact the Case Manager during regular business hours, the 24 hour nurse advice line, the Case Management toll free line with TTY/TTD capability to address immediate concerns.

Harmony's comprehensive Case Management program focus on prevention, coordination of services, education, and specialized programs to effectively assist Members and individuals responsible for the care of the Member. The Case Management program improves the quality of care and quality of life as well as integrate a psychosocial approach to care.

The Member is co-managed by the Case Manager and the Behavioral Health Specialist in tandem to meet the particular needs of the Member. If a Member does not have needs for both medical and behavior health services, the respective Case Manager leads the case on an ongoing and as needed basis.

Rounds between professionals are vital in the care of any Member. Harmony has three different levels of Case Management rounding:

1. RN/MSW Case Manager and Medical Director Rounds occur on a daily to weekly frequency. These discussions are collegial collaborations to direct coordination of care.
2. Medical/Behavioral Health Integrated Rounds occur bi-weekly with the RN Case Manager, MSW Case Manager and, Medical Directors from both Medical and Psychiatric services. Market Medical Directors are included in these rounds to facilitate inclusion of local providers. A unique feature to these rounds is the inclusion of the Member's PCP or Specialist facilitating a venue to engage the PCP/Specialist as an active leader in their patient's care.
3. Quarterly Grand Rounds select the highest complexity Members to be discussed in an open forum with multiple disciplines ranging from surgery, pediatrics, family practice, psychiatry, pharmacy, nursing and social workers.

Member Advocacy
Members are presented with numerous stressors during the rehabilitative phase of any disease process. Harmony's Case Managers act as Member advocates, ensuring access to high quality health care services and educational literature. Case Management's goal is for the Member to focus on achieving optimum health and wellness.

Member Discharge
Members must meet clearly identified criteria for discharge from the Case Management program.
- Stabilization of the Member (condition or functional loss has been regained)
- Services are no longer needed by the Member (optimal health obtained)
- Member is able to perform ADL's wholly or with minimal assistance
- Member is able to self manage
- Member is non-compliant despite multiple and varied interventions by the case or disease managers
- Member request closure
- Member has expired
- All attempts to contact Member or coordinate care are exhausted
- Coverage has been exhausted or transferred to another health care source
- Member has reached 80% or greater of goals established.

Outcome Measurement and Reporting
Financial Outcome:
- Decrease re-admissions
- Decrease ER admissions
- Access appropriate level of care

Clinical Outcome:
- Early identification of Members in their disease process to decrease the potential for adverse outcomes
- Improve adherence to evidence-based care guidelines
- Increased self-care of identified disease state

Reporting:
The appropriate data will be collected from the EMMA system utilizing clinical, statistical and financial metrics.

- Internal reporting for program and staff management purposes- monitoring the performance of the Case Management program as well as the Case Management staff process.
- External reporting provide Case Management performance information to the state, market and internal customers, including clinical outcomes as it relates to the Members.

Harmony Hugs Program Description
Purpose: Harmony Hugs is a support and education program for pregnant Harmony Health Plan members in Missouri. Harmony Hugs is designed to improve care management of pregnant women by starting early in their pregnancy providing educational information and support. The program will also identify members with potential risk factors that may adversely affect the outcome of their pregnancy. Hugs will encourage pregnant women to practice good prenatal care through direct mailings of educational materials, availability of a Harmony Hugs social services specialist for questions and concerns, advocating for consistent follow up with their provider, and appropriate utilization of OB case management.

Goals: The Harmony Hugs Program goals are to identify all pregnant members, more specifically the high risk members, and identify these members early in pregnancy. Harmony Hugs will outreach and enroll these members into the Harmony Hugs Program. Once identified, the program will advocate, intervene, coordinate services and educate members through comprehensive follow ups based on pregnancy risk level regarding their prenatal, peri-natal and postnatal states. The Hugs program will contribute toward improving pregnancy outcomes through coordination of care, education and appropriate referrals to OB case management.

The Harmony Hugs Program will impact the following areas:
- Early identification of pregnancy for timely intervention and education
- Pre-term delivery
- Birth Outcomes
- Medical costs
- ER utilization
- Community resource utilization

Program Benefits to Member:

- Educational materials and advise
- Coordination of care with PCP, OB provider, and case management staff
- Support through pregnancy and post delivery

Program Benefits to Physician
- Better outcomes for their patients
- Support in managing pregnant patients
- Appropriate and timely utilization of medical services
- Pay for Quality incentives based on achieving HEDIS targets

Procedures:
1. Sources of Identification
In order to identify Harmony members early in their pregnancy, the Hugs program will obtain information the following sources:
- EDD Report-a monthly report from the state which identifies a pregnant Harmony member by MO HealthNet number and estimated date of delivery
- Monthly Prenatal Vitamin report
- Member Services
- Member Self Referral
- OB Notification
- Daily Census-referrals from UM nurses based on daily census reports
- Family Case Management and Community Agencies

2. Outreach
Upon receiving notification of a pregnancy, the Hugs social services specialist will mail an outreach letter informing the member about the Harmony Hugs Program. The member will have the option to enroll via phone or mail. Once phone contact is made, the social services specialist will conduct an initial assessment.

3. Assessment
Once the social services specialist makes contact with the member, the social services specialist will conduct an initial assessment of the member. This assessment identifies medical, social and mental health needs of the member and stratifies them in either a high, moderate or low risk level. Referrals to the appropriate resources will be made based on this assessment and the Hugs social services specialist will collaborate services based on the referral made.

4. Follow up
Follow up with Hugs members will occur at least once per trimester or as needed. At each trimester follow up, a short assessment will be conducted to identify any new concerns or needs. Home visits will be made available for moderate to high risk members or upon request of the member.

The social services specialist will provide member with educational materials regarding fetal development, breastfeeding, substance use and pregnancy, teen pregnancy, child development, nutrition as well as other pregnancy related topics.

Social services specialist will also provide Hugs members with community resources and important Harmony numbers. Upon enrolling into the Hugs program, member will receive a complimentary Hugs diaper bag.

Upon delivery, social services specialist will also give post partum and well-child visit reminders to Hugs member. Social services specialist will also conduct the Edinburgh Postnatal Depression Screening (EPDS) and make appropriate referrals based on the depression score.

5. Additional Elements
The following are used to enhance the quality of the Harmony Hugs Program for all participating members in regards to support and education.

- *Newsletter*
- A quarterly newsletter is currently in development and will be sent out to active Hugs members with important information on pregnancy and community resources.

- *Community Agency Collaboration*
- The Hugs social services specialist is actively meeting with community agencies to collaborate services and gain knowledge of available resources in the Hugs members' communities

- *NICU follow up*
- The Hugs social services specialist will also follow up with Harmony members who have delivered prematurely to offer support and assistance through assisting with Social Security Disability applications, home visits and education.

Outcome Measures
- Process Measures
- % of pregnancies identified prior to delivery
- % of identifications by trimester
- Harmony Hugs Participation Rate (Members enrolled in Harmony Hugs/ Total Pregnancies)
- % of enrolled members that are high, moderate and low risk
- Outcome Measures
- HEDIS Prenatal Care rate
- HEDIS Timeliness of Prenatal Care rate
- HEDIS Postpartum Care rate
- Birth weights
- Harmony Hugs Satisfaction Surveys
- NICU admits/ 1000

The above data is presented and discussed at the QIC and Medical Advisory Committee meetings for both IL and MO.

Annual Evaluation
Harmony Hugs will evaluate the program's effectiveness and opportunities for improvements on an annual basis.

Included for review are Hugs Report and a sample Delivery Report under 8.2.

Compliance of Prenatal Care & Post Partum Care
In regards to prenatal care the health plan has reached the 80% goal of timeliness of prenatal care. Harmony Health Plan and Harmony Hugs continue to strive towards maintaining our rates by enhancing the Harmony Hugs perinatal outreach program. Harmony Hugs has implemented several program components aimed at improving member's compliance through the following enhancements: the creation of additional outreach materials (brochures, posters, mail in and internet enrollment forms), member and provider education, mailings, telephonic and in person follow up. In regards to post partum care; the health plan has not reached its goal of 80% compliance. HHPM is continuing to strive towards its goal by enhancing the Harmony Hugs perinatal outreach program. A cause/barrier analysis shows that low post partum rates may be due to the following factors: Discharge planning instructs women to go to post partum visit before the HEDIS designated time frame of 3-8 weeks after date of delivery. During HEDIS chart chases, HHPM quality staff found that women are completing post partum follow up visits but dates are outside the HEDIS timeframe requirements. HHPI also encountered difficulty confirming where members received post-partum care.

From July 1, 2007 until June 30, 2008 the Hugs program has:
- Enrolled a total of 138 members in the state of MO
- Of the members enrolled in MO, 15 were High Risk, 46 were Moderate Risk, and 77 were Low Risk
- Harmony Hugs has increased participation rates tremendously:
    o From Jan-June of 2007 the Harmony Hugs program enrolled a total of 18 women into the Hugs program. From Jan-June of 2008 Harmony Hugs had increased participation by having enrolled 120 women into the Hugs program for the first half of the year.
- There have been 107 deliveries of Harmony Hugs participants of which only 6 had a birth weight below 2499 grams

State of MO Prenatal Rates:

HEDIS MEASURE	Final Rate 2006	Final Rate 2007
PRENATAL/PP CARE		
Timeliness of Prenatal Care	85.29%	86.51%
Postpartum Care	47.06%	55.56%

Disease Management Programs
Harmony's Disease Management Program focuses on the management of chronic longterm conditions. These conditions are costly, complex and require member education to achieve supported self care and behavior modification for desired quality outcomes, both in quality of life for the member and cost-effectiveness.

Harmony offers Disease Management Programs for Asthma and Diabetes. These programs aim to provide an enhanced level of health and empowerment for members to make behavior changes to guide in the choices they make will improve their health and reduce the complications of their disease. The program also provides member and provider education on preventative measures, standards of care; evidence based clinical guidelines or current treatment recommendations.

Program Description
Harmony offers individualized Disease Management services that provide health education, resources in our Member's community, and the promotion of good health throughout our Membership. Disease Management further *integrates* the essential services of behavioral health case management, medical case management, and pharmacy to provide a complete Member centered approach to service facilitation, delivery and coordination of care that meets the Members' needs in a holistic manner; taking into account the Member's medical, social, and emotional needs.
Harmony's philosophy of Disease Management is based on the integration of three disciplines to provide a Member-centric approach. Harmony's integration of medical case management, behavioral health case management, and pharmacy provides added value to the Member while in Disease Management. This integration fosters collaboration between the three disciplines/ departments therefore, providing the member with unparallel continuity of care and care coordination.

The three disciplines combine to provide the Member with traditional *disease management benefits* (coordination of care with providers, health education), *behavioral health benefits* (mental health issues, substance abuse) and *pharmacy benefits* (consults with a pharmacist for Members to better understand medications and medication interactions). The three disciplines work collaboratively to meet the highly complex medical and psychosocial needs of our Members.

Purpose
The purpose of the Disease Management Program is to provide health education and support to Members and assist them in making behavioral changes that promote better health. Disease Management strives for continuity of care, transition of care, and integration of services that focuses on the Member.

Goals
The goals of the Disease Management Program are:
- To identify eligible Members for Disease Management Services
- To provide Members with disease-specific health education and coaching
- To identify barriers to care and develop solutions to those barriers
- To promote health awareness and high quality care
- To offer Members access to superior education specific to their needs or conditions utilizing evidence based guidelines
- To maximize Members' self-management of their condition and care needs

Objectives
The objectives of the Disease Management Program are to:

- Implement health education programs for medically and behaviorally complex Members.
- Conduct a comprehensive assessment and develop a Care Plan with established goals, time frames for reevaluation, resources, interventions and outcomes.
- Provide appropriate referrals as needed i.e. behavioral health, pharmacy, and case management, etc.
- Direct Members in the Disease Management Program to needed resources and appropriate access to services.
- Educate Members on their conditions to assist in obtaining optimum wellness and prevention of complications.

Disease Management Process

The Disease Management process illustrates the formation of one seamless Case and Disease Management program and begins with Member identification, and follows the Member until discharge. Harmony's philosophy is that these programs are an integral management tool in providing a continuum of care for our Members. The Disease Management process is as follows:
- Member Identification
- Member Stratification
- Member Evaluation
- Member Care Planning
- Member Education
- Member Advocacy and Resource Direction

Member Identification

Harmony's integrated philosophy is the foundation of all components of the program, beginning with Member identification. Harmony utilizes traditional methods of identifying Members for inclusion into its Disease Management program. These methods include but are not limited to:
- 24/7 nurse information line referral
- Medical and Behavior Health Program referral
- Pharmacy referral
- Case Management Program referral
- Hospital Discharge Planner referral
- Utilization Management referral
- Intake Coordinator referral
- Concurrent Review Nurse referral
- Member self-referral
- Provider/Practitioner referral
- DM Trigger List

Additionally, on a monthly basis, Harmony uses more proactive methods to identify members potentially needing disease management services. This is accomplished by running proprietary algorithms against claims data from:
- Pharmaceutical, point of sale;
- Medical/professional services; and
- Institutional services

From these algorithms Harmony biostatisticians are able to establish a cohort of members identified as those at the highest risk for poor outcomes and increased utilization of services.

Member Access to Disease Management
Harmony Members have access to Disease Management at any time. The Member can self refer or receive referral by a provider to Disease Management utilizing:
- Health information line referral;
- 24 hour nursing line; or
- Disease Management toll free line (TTY/TTD).

Harmony's Disease Management program is an "opt out" program. Members identified as candidates for the program are categorically enrolled. The Member must actively seek disenrollment to be excluded from services. This enrollment methodology ensures that all potentially qualified Members receive services without having to seek them out.

Disease Management Information Systems
Harmony maintains a health information system Enterprise Medical Management Application (EMMA) that collects, analyzes and integrates the data necessary to implement its quality a Disease Management program. In addition, the information entered into the system is reliable, complete and secure, providing the department with high quality reporting capabilities. The system provides the Disease Manager with automated prompts for Member follow-up and Care Plan intervention implementation. Recorded actions or interactions with the Member assist in providing a clear vision of the Member's needs, goals, interventions and outcomes.

EMMA is transparent, allowing for a comprehensive unobstructed view of the member across all Harmony departments from Intake to Appeals. Member privacy for Private Health Information (PHI) and HIPAA compliance is ensured with security level access assigned on a 'need to know' basis.

Member Stratification
Once the proprietary algorithms are run, the results are run through another set of algorithms to stratified the members into a three tiered system:

> High Risk – Members receive Case Management services.
> Moderate Risk – Members receive Disease Management services.
> Low Risk – Members receive quarterly mailings of newsletters and campaign mailings, i.e., mammogram screening reminders in October, healthy heart reminders in February, etc.

The validity of the data and stratifications can be confirmed by only one method and that is direct assessment of the member. This process begins with those members reached receiving a Mini-assessment (health risk assessment) by a Disease Management Coordinator. The para-professional conducting this assessment is able to ascertain at the conclusion to the assessment as to whether the member is more appropriately served by Case or Disease Management.

The mini-assessment is conducted on all members reached and willing to participate in the Case or Disease Management programs. The Mini-Assessment is not a comprehensive evaluation of the member but it contains some very powerful screening tools. The Mini-Assessment includes:

- Patient Health Questionnaire (PHQ-9) – The PHQ-9 is a screening tool used to determine a Member's depression status. All telephonically screened Members are asked the first two questions of the PHQ-9. If a Member tests positive for this screening, they immediately qualify to be warm transferred to an RN Case or Disease Manager for completion of the PHQ-9. If the Member tests positive in this screening (score of 15 – moderate depression or higher), a warm transfer to a Master in Social Work (MSW) Case Manager or a Behavioral Health (BH) specialist. If the Member is not immediately transferred to BH, the Member is scheduled for a comprehensive assessment with a MSW Case Manager who conducts the assessment with an end goal of creating a comprehensive case/disease management Care Plan.

- CAGE/CAGE-AID - The CAGE (alcohol) and CAGE-Aid (drug) are four questions that have been shown to effectively identify Members who may have a problem with substance abuse. Each affirmative response earns one point. One point indicates a possible problem, which warrants a dialogue with the Member to suggest a referral to a Behavioral Health provider for an evaluation. Two points indicate a probable problem and is the threshold for referring to a BH Specialist.

- Short Form (SF-8) – A standardized tool to establish a baseline and measure over time the Member's perception of wellness.

Member Evaluation
Members that meet criteria for admission into our Disease Management program are scheduled for a comprehensive assessment by a MSW or RN Disease Manager. The Member is provided with program information after entering the Disease Management program i.e. written program information describing available services, correspondence (Welcome Letter), company website information, educational information, etc. The Member is also informed that they have the option to "opt out" and not participate in the program.

The comprehensive assessment is meant to:
- Identify the Member's health status and condition specific issues, including co morbidities;
- Verify current health status and need for healthcare coaching interventions;
- Provide documentation of historical medical information including medications, key events related to condition, hospitalizations, etc.;
- Identify needs (medical, behavioral, social), barriers, and assess activities of daily living and need for assistance;
- Identify cultural and linguistic preferences or limitations and provide assistance as needed. These include a language line, bi-lingual website, multi-lingual telephone prompts and educational literature;
- Provide inclusion of mental health status, social and economic assessment, cognitive functions and life planning (advanced directives, living wills, power of attorney, etc);

- Determine the member's knowledge base, willingness or ability to adhere to the prescribed treatment regime; and
- Gather the information to create a Care Plan with short and long term goals, interventions, follow-up, and outcomes.

Once in the Disease Management program, Members are contacted as needed to provide high quality healthcare education and coaching. This can be multiple times in a week or at least month. This is part of the Care Plan that is developed during the comprehensive assessment.

Members ready for discharge from Case Management are referred to the Disease Management program for continued monitoring and support. Members may contact Case Management at any time for questions or re-enrollment into the program.

The Disease Management Program is comprised of 13 disease states: *(The highlighted conditions are Florida State Requirements)*

- **Asthma**
- COPD
- **Diabetes**
- **CHF**
- CAD
- Obesity – Pediatric
- **Hypertension (HTN)**
- **HIV/AIDS**
- Major Depression
- **Substance Abuse**
- **Smoking Cessation**

Member Planning

Upon completion of the comprehensive assessment, the Care Plan is developed with the information obtained during the assessment. Harmony's Disease Managers utilize the Care Plan as the guiding document for the Member's needs. A schedule for follow-up is system generated to ensure compliance with the established goals in the Care Plan, and to assure the appropriate time frame for re-evaluation. Member planning also includes the need for continued care and addresses issues related to the transition of care or transfers. The Care Plan is viewed as a fluid document that continually drives the Member's care.

Vital to the services provided for the Member, the Care Plan is developed based on nationally recognized standards of care (ADA, APA, etc.) and utilizes evidence based guidelines. The Disease Manager is responsible for creating a Care Plan with the Member, and collaborates with the caregiver, the PCP, and/ or Specialist who are instrumental participants in the development of the Care Plan. The Member is encouraged to self-manage their signs and symptoms, activities, weight, blood pressure and glucose levels. If the Member is incapacitated and unable to participate in the actual planning process, the caregiver, or person/individual responsible for the care of the Member is encouraged to become involved in the planning process.

Upon completion the Disease Manager shares the Care Plan with the Member, treating provider, (PCP, Specialist, and Behavioral Health Provider) and caregiver or individual responsible for the care. The PCP is informed on the available services that Disease Management offers through the provision of a Provider Manual, company website and disease specific brochures, etc. The Care Plan is forwarded to the PCP for signature and inclusion into the Member's medical record.

Member's Service Facilitation
The Member and Case Management contact is dynamic and ongoing for the duration of the Member's needs. The Case Management staff contact the Member as necessary to manage the case. The Member's level of service is based upon the level of acuity as determined during the assessment and Care Plan development phase. The Care Plan is continuously updated to assess ongoing needs, progress, and/ or set new goals. The Member or individual responsible for the care of the Member has the ability to directly contact the Disease Manager during regular business hours, the 24 hour nurse advice line, the Disease Management toll free line with TTY/TTD capability to address immediate concerns.

Harmony's comprehensive Disease Management program focuses on prevention, coordination of services, education, and specialized programs to effectively assist Members and individuals responsible for the care of the Member. The Disease Management program improves the quality of care and quality of life while integrating a psychosocial approach to care.

The Member is co-managed by the Disease Manager and the Behavioral Health Specialist in tandem to meet the particular needs of the Member. If a Member does not have needs for both medical and behavior health services, the respective Disease Manager leads the case on an ongoing and as needed basis.

Rounds between professionals are vital in the care of any Member. Harmony has three different levels of Case Management rounding:

1. RN/MSW Disease Manager and Medical Director Rounds occur on a daily to weekly frequency. These discussions are collegial collaborations to direct coordination of care.
2. Medical/Behavioral Health Integrated Rounds occur bi-weekly with the RN Disease Manager, MSW Case Manager and, Medical Directors from both Medical and Psychiatric services. Market Medical Directors are included in these rounds to facilitate inclusion of local providers. A unique feature to these rounds is the inclusion of the Member's PCP or Specialist facilitating a venue to engage the PCP/Specialist as an active leader in their patient's care.
3. Quarterly Grand Rounds select the highest complexity Members to be discussed in an open forum with multiple disciplines ranging from surgery, pediatrics, family practice, psychiatry, pharmacy, nursing and social workers.

Member Advocacy
Members are presented with numerous stressors during the rehabilitative phase of any disease process. Harmony's Case or Disease Managers act as Member advocates, ensuring access to high quality health care services and educational literature Disease Management's goal is for the Member to focus on achieving optimum health through education and wellness programs.

Member Discharge
- Members must meet clearly identified criteria for discharge from the Disease Management program.
- Services are no longer needed by the Member (optimal health obtained)
- Member is able to perform ADL's wholly or with minimal assistance
- Member is able to self manage
- Member is non-compliant despite multiple and varied interventions by the case managers
- Member opts-out of the Disease Management program
- All attempts to contact Member or coordinate care are exhausted
- Coverage has been exhausted or transferred to another health care source
- Member has expired

Outcome Measurement and Reporting
Financial Outcome:
- Decrease readmissions
- Decrease ER admissions
- Access to appropriate level of care

Clinical Outcome:
- Early identification of Members in their disease process to decrease the potential for adverse outcomes
- Improve adherence to evidence-based care guidelines
- Increased self-care of identified disease state

Reporting:
The appropriate data will be collected from the EMMA system utilizing clinical, statistical and financial metrics.
- Internal reporting: for program and staff management purposes monitoring the performance of the Disease Management program as well as the Disease Management staff process.
External reporting: provide Disease Management performance information to the state, market and internal customers, including clinical outcomes as it relates to the members.

Mental Health Care Management including Case Management
Key Accomplishments
- The ICM Team developed the structured BH Comprehensive Case Management Assessments and Problems-Goals-Interventions Care Plans, and they were embedded in EMMA, the new, fully integrated medical management information system. The Team served as ―Test pilots‖ in EMMA in first quarter 2008. Structured comprehensive behavioral health case management assessments and individualized, specific case management care plans are embedded in the system, which allows a organized, focused, member-centric approach to member care management. EMMA allows fully integrated medical and behavioral case management, as all assessments, care plans, and case notes completed by the health plan case and disease managers, pharmacy, utilization

management and BH ICM Care Management are transparent. Effective the end of second quarter, the entire ICM Team was working in EMMA.

- In the fourth quarter of 2007, the Healthplan Disease Management Programs implemented behavioral health screening into their overall member health risk screening that is provided to all newly enrolled members.

- The three screens utilized are for depression, post partum depression, and substance abuse. Those members identified as having BH conditions or significant symptoms stratified for either referral to BH Intake for referral and linkage to BH providers, or to BH Triage for further assessment, or to the BH ICM Program if criteria are met.

- Led the initiative to develop workflows for IL members identified as having substance abuse disorders and treated in inpatient detoxification. The initiative involved the offer of ICM/MBCM to those who meet criteria and the offer of behavioral health coordination of care services to those who do not meet criteria for ICM/MBCM but are in need of follow-up active substance abuse treatment following inpatient detoxification.

- A workflow was developed in fourth quarter of 2007 and an ICM Team *C-STARS and HUGS*-dedicated Case Manager was selected for successful collaboration with the MO state-mandated C-STARS and the *Harmony HUGS* program, both of which target women with pregnancies and identified substance abuse and mental health presenting problems.

- Health Plan Case Coordinators and Case Managers screen women who are perinatal or postpartum, using the Edinburgh Postnatal Depression Scale to screen for depression and risk for postpartum disorders. Members with positive scores are referred to the HBH ICM or MBCM Programs as indicated by presenting conditions.

- During the second quarter of 2008, selection criteria for the ICM Program were revised so that they are evidence-based and likely to target those members at risk for readmission to higher levels of care and for poor behavioral health outcomes.

X. . Intensive Case Management/Medical Behavioral Case Management
The Intensive Case Management Program (HBH ICM Program) is a program for managing care of members who have had, or are likely to have a significant negative change in their mental health status that could be positively impacted by intervention in excess of that afforded by the traditional care management utilization review process. The ICM program targets select at-risk populations and focuses on clinical and social service solutions for members who may require greater levels of assistance because of the severity, complexity and duration of their behavioral conditions. ICM Care Managers engage members and their supports to develop solutions for problems within the member's system of support and care. ICM Care Managers coordinate activities across all levels of care to avert the need for hospitalization, re-hospitalization or prolonged intensive behavioral health care services, and to improve patient health-related quality of life and overall life functioning.

Members enrolled in the HBH ICM Program may be identified at any point in their interaction with HBH, including at initial intake, during acute care episodes in facility based care, or following discharge from facility-based care. The process of identifying members for the ICM Program involves a comprehensive review of risk criteria by the clinical team. The ICM program is designed to be dynamic and fluid: selected members are assigned to the ICM program are provided intensive management until they achieve functional stability and increased community tenure, and are then transitioned out of the program where they will be followed as needed through the standard HBH care management process.

The Medical-Behavioral Case Management Program (MBCM) is a uniquely structured program which provides integrated medical and behavioral case management services for health plan members with complicated medical and behavioral health conditions. Multidisciplinary coordination of medical and behavioral health care services is achieved through paired assignments of skilled clinical care managers from WellCare's operationally integrated medical and behavioral care management units.

The objective of the MBCM program is to improve the quality of care delivered to members with coexisting psychiatric and medical disorders through increased access to needed behavioral health services and reduced avoidable medical costs associated with untreated psychiatric conditions. Experience in direct care and managed care settings have consistently demonstrated the value of coordination of services for persons with significant medical and psychiatric conditions. The presence of co-morbid medical and psychiatric conditions leads to greater morbidity and burden of disease, overall utilization of healthcare resources, and mortality. Co-existing conditions also significantly affects functional capacity and quality of life for both patients and their family members. Numerous published studies have shown that coordinated intervention among medical and behavioral health care delivery systems can significantly improve desired clinical and economic outcomes.

The MBCM Program offers coordination of care for members who might otherwise have fragmented care or unrecognized and thus untreated condition(s) leading to unnecessary utilization of health care services. The MBCM Program emphasizes the importance of coordination with primary and specialty care physicians, behavioral health and allied health providers, and community social service agencies to maximize positive clinical outcomes and improve health related quality of life.

The 2007 ICM/MBCM goals were as follows:
- Reduce overall readmission rates by 5%.
- Reduce overall health care costs of ICM members by an average savings of $3,000 / 6 month interval post ICM enrollment.
- Develop additional outcome measures for ICM program to measure impact.
- Develop and evaluate caseload thresholds for ICM staff. Maintain case load of 30-40 cases per ICM care manager.
- Expand partnership with Health Services to increase referrals to ICM and MBCM programs and increase medical-behavioral integration outcomes for our members.

Additional ICM/MBCM measurable objectives in 2008 are as follows:

- Increase days in community without acute care readmissions post-ICM
- Implement evidence-based selection criteria for the ICM Program.

Significant accomplishments for the ICM/MBHO programs:
In the fourth quarter of 2007, the [Medical] Disease Management Programs implemented behavioral health screening into their overall member health risk screening that occurs at enrollment of new members or when

a) Depression Screening:
The PHQ-9 is a widely validated tool used by practitioners and managed care organizations for screening of depression. Nationally-developed protocols have been developed to utilize the PHQ instrument to determine the most appropriate course of treatment, relative to severity of a patient's depression, and to monitor ongoing care. The PHQ-2, which is initially administered, includes the first two items [of the PHQ-9] as the initial screening. If the member responds affirmatively to either of these two items, the member is queried about the remaining seven (7) items. This approach is considered by many organizations to be an efficient way to screen large numbers of patients for purposes of detecting undiagnosed depression in populations.

The PHQ-9 is based upon the diagnostic criteria for Major Depressive Disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). Research has shown that certain scores on the PHQ-9 are strongly correlated with a diagnosis of Major Depressive Disorder. However, every patient with an elevated PHQ-9 is not certain to have Major Depressive Disorder. Therefore, the PHQ-9 is not intended to be a substitute for a face-to-face evaluation and diagnosis by a trained clinician.

b) Post Partum Depression Screening:
The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for post partum depression. The EPDS is easy to administer and has proven to be an effective screening tool. Medical Case Managers administer the EPDS with pregnant members or members who have recently given birth and respond accordingly, depending on the member's EPDS score. A score of ten (10) to thirteen (13), which indicates possible depression, warrants a dialogue with the member to recommend referral to a behavioral health provider for an evaluation. A score of greater than thirteen (13) warrants a referral to the medical-behavioral case management program.

c) Substance Abuse Screening:
The CAGE (alcohol) and CAGE-Aid (drug) are brief screens consisting of four questions that have been shown to effectively identify members who may have a problem with substance abuse. Each affirmative response earns one point. One point indicates a possible problem, which warrants a dialogue with the member to suggest a referral to a behavioral health provider for an evaluation. Two points indicate a probable problem, and is the threshold for referring to Behavioral Health Case Management. Despite its prevalence and the degree to which it complicates health conditions, substance abuse in most patient populations is undiagnosed. The Case and Disease Management programs are in an ideal position to help identify, prevent, and treat substance abuse/dependence by effective screening and intervention.

During Quarter 1, 2008, a partial team of ICM Program Case Managers began working as ―test pilots" in the new fully integrated management information system, EMMA. During Quarter 2, the remainder of the team began working exclusively in EMMA, which has structured comprehensive behavioral health case management assessments and individualized, specific case management care plans embedded in the system. EMMA allows fully integrated medical and behavioral case management, as all assessments, care plans, and case notes completed by the health plan and behavioral health teams are transparent.

Documentation notes in EMMA include completed assessment, individualized care plan, coordination of care with community resources, PCP involvement in aftercare as appropriate, and provision of follow-up services. Member contacts and Case notes are Problems-Goals-Interventions-member response-driven.

In Quarter 2 2008, a non-clinical position was added to the team to process all referrals, complete the initial engagement of members, and complete enrollment in EMMA, which increased efficiency of the team.

Barriers: Program growth was limited by care manager workload capacity and open replacement and new positions. There has been a substantial delay is ability to obtain outcomes data due to waiting periods for increased EMMA functionalities and business analytics staff resources to design and generate reports.

Analysis: The goals for service year 9/1/2007-6/30/08 for MO were to increase enrollment of eligible MO members in ICM/MBCM; to increase our understanding of MO member population characteristics and needs; to increase our understanding of any network or community service gaps that interfere with access to services; and to reduce gaps.

Recommendations for fiscal year 2008-2009 include:
- Prioritization of both qualitative and quantitative outcome studies to evaluate the effectiveness of the ICM program and to develop action plans to further enhance the program.
- Develop targeted population-specific protocols of interventions to enhance opportunities for positive outcomes for members with resource allocation to meet the specific challenges of the populations.
- Continue goal to increase eligible MO members enrolled in both ICM and MBCM by collaborating with HBH Utilization Management Teams and healthplan Utilization Management and Case and Disease Management to identify eligible members.

I. Census, Referrals and Discharge Activity

	9/07	10/07	11/07
Census	0	1	1
ICM	0	1	1
MBCM	0	0	0
Referrals	0	1	0
ICM	0	1	0
MBCM	0	0	0
D/Cs	0	0	0
ICM	0	0	0
MBCM	0	0	0

	9/07	10/07	11/07
C-STAR Coordination Cases:	0	0	0

II. Analysis / Summary:
- 1 member was enrolled in the ICM program at the end of November, 2007
- No members were referred to ICM or MBCM
- No members were discharged from ICM or MBCM

III. Opportunities:
- Continue to identify appropriate candidates for the ICM or MBCM program through collaboration with the Missouri inpatient Care Manager and with Health Services UM and Case Management staff

Effective first quarter 2008, the program began to report MO Members Served by LOB and by Program.

Behavioral Health Intensive Case Management Report
Missouri
January 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	0	0	1	1	2
MMR	0	0	0	0	0
Total	0	0	1	1	2

287

Behavioral Health Intensive Case Management Missouri February 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	1	0	1	0	2
MMR	0	0	0	0	0
Total	1	0	1	0	2

Behavioral Health Intensive Case Management Missouri March 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	1	0	1	0	2
MMR	0	0	0	0	0
Total	1	0	1	0	2

Behavioral Health Intensive Case Management Missouri April 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	0	0	4	0	4
MMR	0	0	0	0	0
Total	0	0	4	0	4

Behavioral Health Intensive Case Management Missouri May 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	0	0	5	0	5
MMR	0	0	0	0	0
Total	0	0	5	0	5

288

Behavioral Health Intensive Case Management
Missouri June 2008
MEMBERS SERVED

LOB	ICM	MBCM	HUGS	C-STARS	Total
MMD	0	0	5	0	5
MMR	0	1	0	0	1
Total	0	0	5	0	6

Analysis January 1-June 30, 2008
The Missouri MMD membership has ranged from 9,778 in January to 11, 859 in June 2008. The MMR membership ranged from 317 in January to 961 in June 2008. The presentations for psychiatric inpatient level of care on monthly average are less than 10 for MMD and less than 5 for MMR. There is a small, high risk population that appears to drive utilization.

Opportunities: There is opportunity to increase the number of members enrolled in ICM and in MBCM and to select the high risk members. The members who are driving the utilization have the same clinical and other characteristics of members in all states that are at high risk for readmission and poor health and behavioral health outcomes— diagnostically Severely and Persistently Mentally Ill with co-morbid Substance Abuse, low supports, a pattern of non-adherence, lack of meaningful engagement in treatment, and low readiness for change.

Recommendations: Initiate Risk for Readmission Rounds to staff members currently in BHI level of care in order to score risk, identify members for referral to ICM/MBCM; to develop the reducing g risk for readmission plan; and to initiate the interventions when the member is still on the inpatient unit whenever possible.

CSTAR Coordination Procedure For Pregnant Members
A pregnant woman under MC+ Managed Care may be identified as a substance abuser by her primary care provider, a Harmony Behavioral Health (HBH) Case Manager or MO QI Annual Harmony Health Plan (HHP) Case Manager as a result of reviewing history, utilization patterns, CAGE AID results, current presentation, or any combination of variables that suggest drinking or drug abuse during pregnancy. When this occurs, the member is referred to a specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) provider.

The HBH ICM Care Manager serves as a resource in helping facilitate this referral and subsequent communications with PCPs and other relevant parties as needed and appropriate, using the following procedure:

- If any HBH staff member identifies a pregnant member who is abusing drugs or alcohol, the member is referred to the Intensive Case Management (ICM) Program.

- A referral to a CSTAR provider from an HBH ICM Care Manager may be accomplished using the MC+ Managed Care Screening and Referral Form or with a phone call to the appropriate ADA CSTAR provider within the MC+ Managed Care health plan region.

- The Multiparty Consent for Release of Information is completed by the HBH ICM Care Manager and signed by the member during referral

- The member is referred to a Specialized CSTAR Program for Women and Children.

- When the HBH ICM Care Manager contacts the CSTAR provider with a referral, the CSTAR provider schedules an assessment immediately or at the soonest time possible for the member.

- In the event any difficulties are encountered with the referral process, the HBH ICM Care Manager contacts the ADA Clinical Review Unit.

- The HBH ICM Care Manager will assure that the patient has transportation to the CSTAR program site.

The CSTAR provider conducts a comprehensive assessment and diagnostic evaluation in accordance with Department of Mental Health protocols to determine treatment needs and the appropriate level of care. It is imperative for the long term success of the pregnant member that there is clear and consistent communication among the CSTAR provider, PCP, HBH, HHP and The ADA Clinical Review Unit.

- In situations where the Harmony Behavioral Health (HBH) contact is different from the Harmony Health Plan (HHP) case manager, HBH and HHP will decide who will take the lead on case management activities.

- The ADA treatment provider will be informed by the HBH ICM Care Manager who will be assuming this role to ensure clear and effective communications.

  o Significant treatment events that prompt communication are referral, admission, eligibility notification, barriers to treatment progress, critical issues or incidents, aftercare and discharge planning, and discharge date. *(Examples of critical issues or incidents include, but may not be limited to, deferred admission for medical reasons; relapse; discharges against staff advise; need for detoxification services, consultation regarding medication-assisted protocols, transitions from residential to outpatient levels of care, etc.)*

- The CSTAR provider should make every effort to plan consumer discharges in consultation with the Primary Care Provider (PCP) or OB/GYN and the HBH or HHP case manager.

- If consumer is not a HHP member at admission, but obtains such benefit prior to transfer to outpatient services and/or discharge from a residential treatment setting, the protocol should be implemented for the remainder of the treatment episode. *However, eligibility status MUST*

290

be rechecked by the CSTAR provider 3 days prior to discharge/transfer and then daily until discharge/transfer.

- The HBH ICM Care Manager will be contacted by the ADA treatment provider to inform him or her of the planned discharge date and request assistance in collaborating aftercare (continuing care) and discharge plans with the PCP or OB/GYN if needed. Aftercare plans developed prior to discharge should include a return appointment with the PCP, as well as, follow-up instructions with the HBH or HHP case manager.

- The HBH ICM Care Manager will request a copy of the aftercare (continuing care) plan, and discharge summary from the CSTAR provider, and ensure that the PCP or OB/GYN also has a copy of this document whenever possible.

- The ADA treatment provider and the HBH ICM Care Manager can determine what additional documentation or information, if any, needs to be provided to the PCP or OB/GYN, and how that information will be relayed.

- The pregnant or post-partum member then receives follow-up services from the PCP or OB/GYN and MBHO in accordance with the aftercare plan.

- If the aftercare and discharge plans include a referral to another treatment provider, the HBH ICM Care Manager will follow-up with the member to ensure he/she made contact with the new treatment provider.

***The goal of the above protocol is to involve as many potential supports in a woman's journey to recovery and to do whatever possible to promote the birth of a healthy baby.*

Clinical Practice Guidelines
Harmony/WellCare adopts clinical practice guidelines and utilizes the guidelines as a clinical tool. While clinical judgment may supersede the clinical practice guidelines, the guidelines provide associates and providers with procedures, pre-appraised resources and informational tools to assist in applying evidence from research in the care of individual members and populations. The clinical practice guidelines are based on medical evidence and are relevant to the population served.

Credentialing and Re-Credentialing
Organizational Structure
The Credentialing and Peer Review Committee is the Missouri principal physician committee that reviews and makes recommendations on credentialing, re-credentialing, and peer review activity. In 2007-2008 the Missouri Credentialing and Peer Review Committee met eleven times at monthly intervals. The Committee is chaired by the Missouri Medical Director and membership includes the Director of Credentialing, Corporate Medical Director of Quality and two participating Missouri physicians. The Credentialing Committee reports to the Quality

Improvement Committee. The Quality Improvement Committee reports its activities to the Board of Directors.

Scope and Methodology
Corporate Credentialing provided credentialing services for Harmony Health Plan of Illinois, Inc. – Missouri. Credentialing services included, initial credentialing, recredentialing, disciplinary action monitoring, maintenance/compliance of credentialing documentation and full administrative support for the Credentialing and Peer Review Committee functions, agendas, reports, minutes, etc. Re-credentialing was not required for this timeframe. Thirty-five credentialing policies and procedures were maintained current to incorporate state contract, regulatory and/or accreditation changes. File processing volume, productivity and turn-around-times were measured monthly.

Initial Credentialing
The target turn-around-time for new application processing was set at 93% of files to be completed within 23 business days. (Industry standard is 100% within 180 calendar days). Monitoring was performed on a monthly basis. 453 new applicants were presented to Credentialing Committee.

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
0	50	43	42	21	26	42	47	30	18	45	89	453

Results
Eighty Five per cent were processed within 23 business days. Fourteen per cent exceeded the 23-day processing timeframe and 1% of files were complex. Quality review indicated 99% accuracy.

Re-credentialing
In 2008 a total of 3 re-credentialing applications were presented to Credentialing Committee.

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
0	0	0	0	0	0	0	0	1	2	0	0	3

Results
Review of provider re-credentialing indicates provider re-credentialing was not required during this timeframe. We did re-credentialing a total of three providers due to these providers having a contract with our Illinois business. To keep the providers in the same cycle we re-credentialed these providers early.

Credentialing Delegation Oversight
Credentialing performed credentialing delegation oversight of five (5) IPA's/ PHO's and four (4) ancillary services providers (Dental, Hearing, Pharmacy, and Fitness services).

Results
Substantial audits were performed for all nine (9) delegations which resulted in one (1) delegations being placed on a corrective action plan. Successful completion the CAP requirement was met.

Licensure and Sanction Monitoring
Licensure and sanction monitoring is performed on a monthly basis.

Results
No participating practitioners were identified as having Licensure issues.

No participating practitioners were identified as having MO HealthNet or Medicare sanctions.

Four practitioners were subject to immediate suspension/termination due to failing to renew licenses.

Analysis
New application processing increased in 2007–2008 over 2006-2007 by 215 applications.

Sanction monitoring stayed consistent with 2006-2007.

Barriers
Barriers were encountered relative to meeting department goal related to Turn-Around Time.

- Difficulty in obtaining credentialing applications with all necessary attachments;
- Resource challenges in a high business growth period;
- Need for personal intervention from the Provider Relations Team;

Improvements
In the second half of 2007 corporate credentialing staffing was increased by five associates;

In the last quarter of 2007 a dedicated delegation oversight team was established with two additional associates;

Credentialing has established regular meetings with the Missouri Provider Relations Team and obtained support in performing provider follow-up relative to:

- Collecting information for applications that are at risk of exceeding the 23 business day turn-around time;

- Collecting rosters and provider updates relative to delegated providers.

Based on evaluation of needs, the re-credentialing team with support from Provider Relations as outlined above has the capacity to meet Missouri demands in 2008 - 2009.

Plans for 2008 - 2009
- Provide monthly state specific service level statistics with a target of 93% of new applications processed in 23 business days;
- Ensure compliance with the 3-year re-credentialing cycle is met;
- Ensure credentialing delegation oversight is performed timely;
- Ongoing review, revision and approval of credentialing policies and procedures;
- Continue to support the Credentialing Committee and Peer Review processes.

Medical Record Review

Harmony Health Plan of Missouri has a process in place to perform medical record reviews for providers of services for our members. During the first year the medical record process revealed opportunities for improvement in documentation. A Medical Record Review Performance Improvement Project (PIP) was initiated to improve documentation in medical records. The pass rate on the initial medical record reviews was 45%. The process used, statistics, and tools follow.

MEDICAL RECORD REVIEW PROCESS
1. Medical records of PCPs should be audited within 1 year of contracting, then every 2 years thereafter.
2. For each PCP with fifty members or more, the QI Analyst will audit five randomly selected records per physician. The members are identified from the provider's eligibility list.
3. The QI Analyst schedules, conducts and summarizes the findings of each medical record review.
4. To achieve a passing score the physician must score 80% or better. The physician will be responsible for a plan of correction when the score is less than 80%.
5. The review period for:
   - ➤ A provider who has been contracted with us for one year is the prior year.
   - ➤ All other providers will be the prior two years.
   - ➤ Providers who scored less than 80% will receive a re-audit within 90 days from the date the corrective action plan was received by the provider.

Prior to Medical Record Reviews the QI Analyst:
- ➤ Identifies providers for medical record review
- ➤ Generates a member eligibility list for each provider.
- ➤ Determines the five members based on claims or encounters in Diamonds.
- ➤ If no claims or encounters in Diamonds then ask the office to pull five Harmony charts for the review
- ➤ Calls the office to schedule a time for the review
- ➤ Faxes or mails the Introductory letter, audit tool and, if applicable, the list of members.

During the medical record review the QI Analyst will:
- Use one medical record review tool per chart
- Complete the physician score card after the review to determine the physician's score:
   - ➤ determine the total possible points by allotting 1 point to each yes and no answer
   - ➤ determine the physician's points by allotting 1 point to each yes answer

> ➢ determine the physician's score by dividing the physician's point total by the total possible points.

- If the score is less than 80%, then a plan of correction will need to be completed.
- Complete the exit interview form that identifies the deficits found during the review

There are two ways the information can be filtered out to the physician or designee.
1. While at the office the QI Analyst can conduct an exit interview after the review is complete. Once the QI Analyst summarizes the findings of the review the physician or designee will need to sign the bottom of the exit interview form and, if applicable, the plan of correction. The physician or designee will receive a copy of the audit tools, the exit interview and, if applicable, a plan of correction.
2. The QI Analyst will not conduct a formal exit interview while at the physician office. The QI Analyst will mail the findings to the physician. The mailing will include a self-addressed stamped envelope, the pass/fail provider letter, a copy of the medical record audit tools, the exit interview form and, if applicable, a plan of correction.

If the physician chooses not to return the signed plan of correction then Harmony will consider that the physician was in agreement with the findings and the plan of correction. This statement is also located in the fourth paragraph of the Provider Fail Letter. If the signed plan of correction is received by Harmony a ―Thank You" letter for the plan of correction will be mailed to the physician.

A file should be maintained for each physician. The file should contain:
1. The introductory letter with the list of five members
2. The audit tools
3. The Physician score card
4. The signed Exit Interview
5. If applicable, the signed Plan of Correction
6. If applicable, the Provider Pass/Fail Letter
7. If applicable, the Provider Thank You Letter

The results of the medical record review will be tracked in the MRR Tracking Log.

If the physician scores less than 80% then a re-audit will be completed 90 days after the receipt of the plan of correction. The re-audit process is the same as the audit process with the exception of the review period. The review period is from when the plan of correction was received by the physician to the date of the re-audit.

Subcontractor Monitoring
Delegation Oversight Committee
The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation;

completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

The Delegation Oversight Committee reports to the Quality Improvement Committee. The Missouri Delegation Oversight Committee met eleven 11 times in 2007. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2007, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicare and MO HealthNet Regulatory Affairs.

The Delegation Oversight Committee coordinated compliance with regulatory, contractual, and accreditation standards for 10 delegated entities by maintaining appropriate policies and procedures; completing pre-delegation audits; executing delegation; completing annual delegation audits; monitoring vendors on corrective action; monitoring vendor data submission and performance reporting. There were no delegated entities terminated and 4 new delegation arrangements implemented.

Committee Initiatives/Focus for 2008
- Maintain appropriate policies and procedures.
- Monitoring potential delegation activities.
- Completing pre-delegation audits.
- Executing delegation implementation.
- Completing annual delegation audits.
- Monitoring agencies on corrective action.
- Monitoring vendor reporting and data submission.

HealthCare USA

Provider Satisfaction

Coventry Health Care, on behalf of HealthCare USA, in an effort to improve the quality of customer service offered to providers, contracts with DSS Research to assess its providers' satisfaction with the customer service center. The objectives of the study include:
- Measure overall provider satisfaction with the Customer Service Center
- Identify reasons for calling customer service
- Determine overall provider satisfaction with the length of time to provide information and resolve issues.
- Examine provider satisfaction with specific elements of customer service

A random sample of providers were used, with an equal number of primary care providers (PCP) and specialists included (200 each for a total of 400 providers included). The overall response rate was 39.8 percent. PCPs accounted for 46.0 percent and specialists 33.5 percent. All results are from the DSS Research report.

Overall Satisfaction with Coventry Customer Service

Percent responding completely, very or somewhat satisfied

	2006	2007	2008	2008 Cvty Avg
	85%	91%	85%	87%

Overall Satisfaction with Coventry Health Care Plan

Percent responding completely, very or somewhat satisfied

	2006	2007	2008	2008 Cvty Avg
	86%	89%	83%	85%
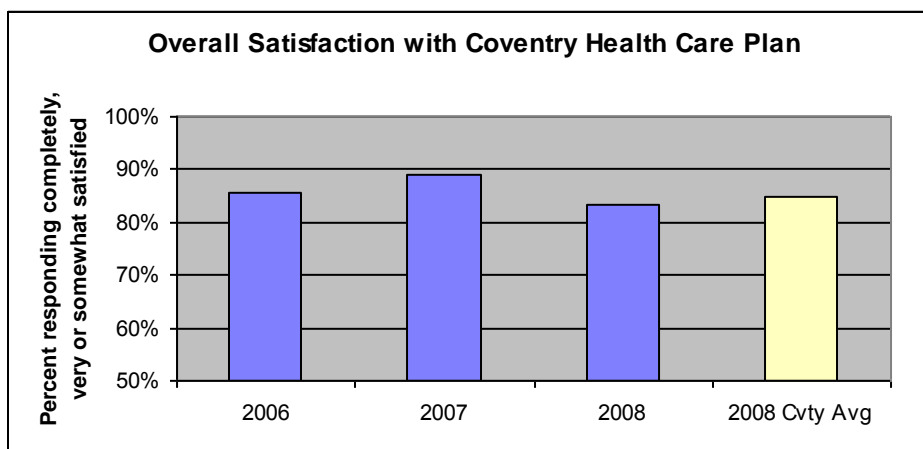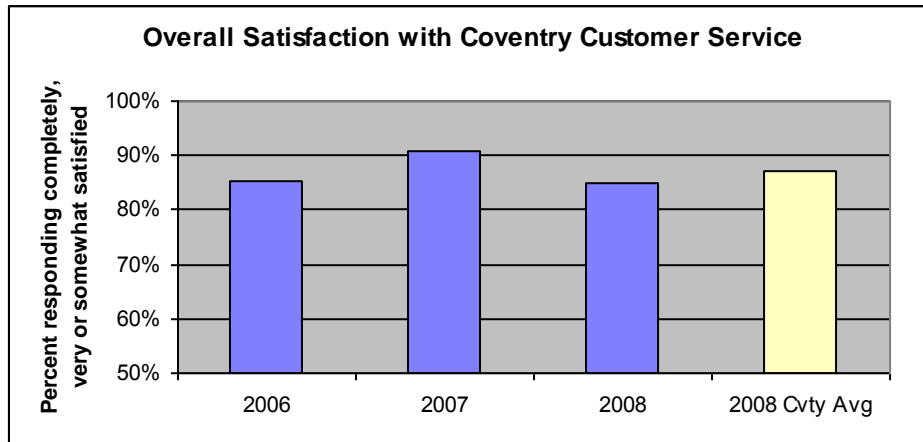
The HealthCare USA rates for Overall Satisfaction with Coventry Customer Service and Overall Satisfaction with the Coventry Health Care Plan declined in 2008. Neither are statistically significant reductions. This decline is most likely attributable to the expansion of the provider and member network in the first quarter of 2008, and the associated increase in the number of providers who are unfamiliar with HealthCare USA processes.

Satisfaction with Timeliness of Claims Payment

Percent responding completely, very or somewhat satisfied

	2006	2007	2008	2008 Cvty Avg
	89%	85%	78%	84%
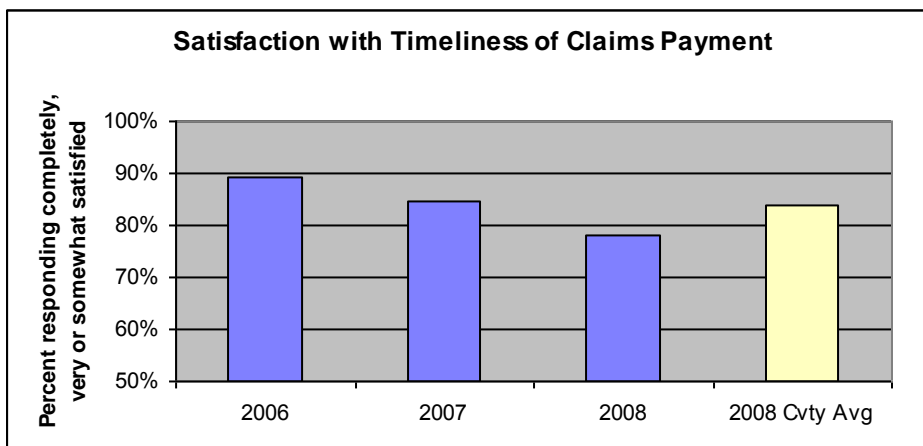
Satisfaction with Timeliness of Claims Payment also decreased from the previous year. The turn-around time for claims payment averages 99.8 percent of all claims process within 30 days with a 99.9 percent financial accuracy.

Satisfaction with Coventry Health Care's Pharmacy Formulary
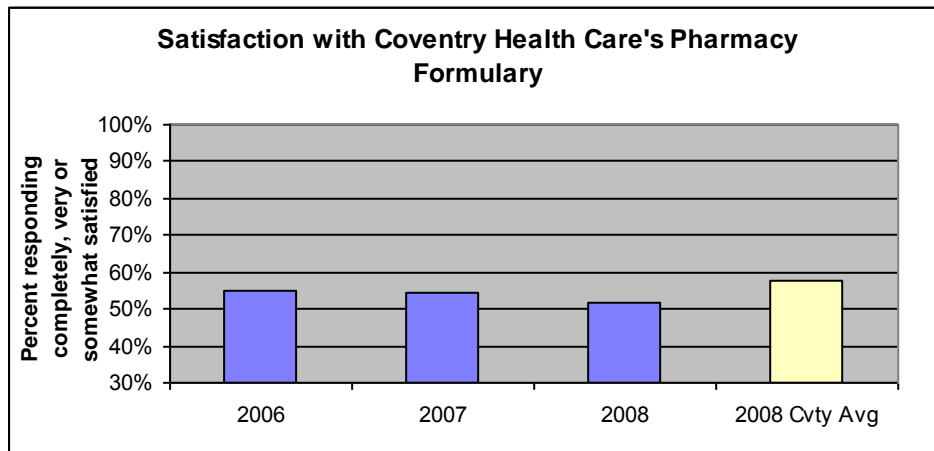
Satisfaction with Coventry Health Care's Pharmacy Formulary decreased as well.   Formulary is a topic that continues to be addressed at the corporate level, in Medical Management Committee meetings and with the Physician Advisory Council. Member services continues to educate providers about formulary limitations so they may better assist our member population. This area is also reviewed at the appeals and grievance level on an on-going basis.

Satisfaction with Overpayment Recovery Process

A bar chart titled "Satisfaction with Overpayment Recovery Process" with y-axis labeled "Percent responding completely, very or somewhat satisfied" ranging from 50% to 100%. Bars for 2006 (~70%), 2007 (~68%), 2008 (~61%), and 2008 Cvty Avg (~67%).
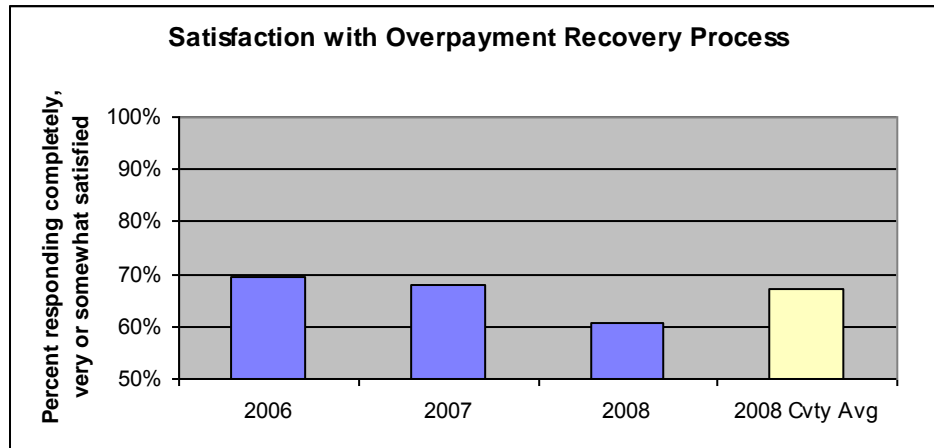
Providers voiced improvement would be finding a better way to take back money and giving providers a chance to pay back the overpayment. Customer service and provider relations continue to educate providers on how to read EOBs and to explain the recovery process.

Satisfaction with Ease of Referral/Authorization Process

A bar chart titled "Satisfaction with Ease of Referral/Authorization Process" with y-axis labeled "Percent responding completely, very or somewhat satisfied" ranging from 50% to 100%. Bars for 2006 (~80%), 2007 (~79%), 2008 (~69%), and 2008 Cvty Avg (~76%).
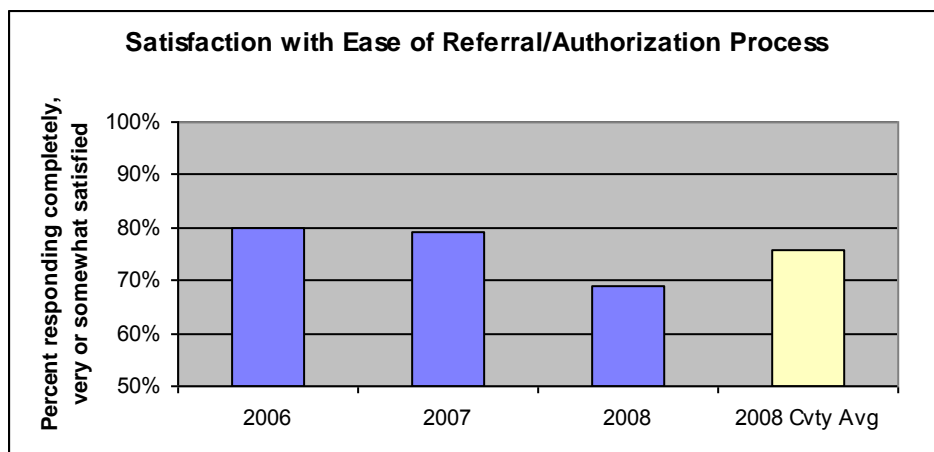
Satisfaction with Ease of Referral/Authorization Process decreased from the previous year. Interventions include educating providers about updates to authorizations. Providers have dedicated provider relations specialists and member services that are able to answer all authorization inquiries. Providers also receive a quarterly newsletter on updates. Providers also have the option of utilizing the online process with ―Direct Provider".

Care Coordination
Special Needs
The Special Needs Department is comprised of two Licensed Practical Nurses that are responsible for screening those members identified as Special Needs by the State of Missouri, Division of Medical Services during initial enrollment. The Special Needs Coordinators educate the members on their benefits, provide community resources to the member as appropriate, and refer them to case management as needed. The coordinator determines whether the member will benefit from Complex Case Management or Disease Management and makes referrals accordingly.

Referrals for possible case management or disease management can be made by automated claims review and NavCare flag, concurrent review, pharmacy or any other staff member, physicians, social workers, school nurses, the member themselves or anyone responsible for the member. All referrals are assessed and services provided as needed.

In 2008, a Special Needs Coordinator was designated to act as a resource person for members with autism and for providers authorizing services for members with autism. This SNC works closely with Judevine Center in the Eastern Region and with Provider Relations in developing services in the Central and Western Regions.

The Special Needs Coordinator is also following all members who are in the Rankin Jordan Pediatric Rehab Hospital. The SNC participates in discharge planning, including going on-site, and arranging services post discharge. The Special Needs Coordinator also has a close relationship with the Special School District in St. Louis.

Outcomes of Special Needs Referrals Percentages

A line graph titled "Outcomes of Special Needs Referrals Percentages" with the y-axis ranging from 0% to 80% and x-axis showing quarters 3Q07, 4Q07, 1Q08, 2Q08. Series: Member Not Reachable, No Case Management, Referred to Case Management, Policy Termed.

Source: Navcare Case Mgt System
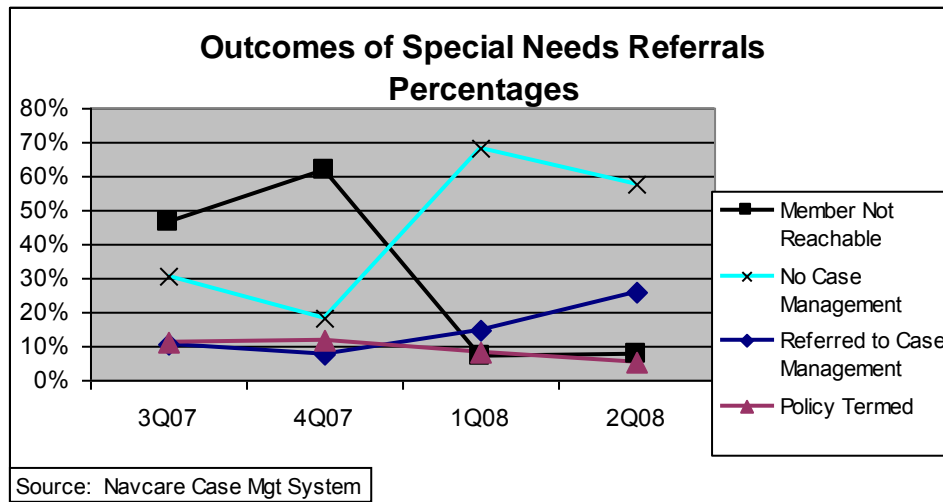
In FY 2008, the Special Needs Coordinators received referrals for 3780 members and was able to contact 70 percent of those members for assessment. Variation in the rate of members not reachable is due to challenges in collaboration with the Family Support Division (FSD). The FSD has been able to provide updated demographics when the member is originally unreachable, but staffing does not always allow them to provide assistance. In addition, there were staffing fluctuations in the Special Needs Department that did not allow for the persistence and tenacity needed at times to reach a member. The rate of members not reachable has improved since 4th quarter 2007, with a fully staffed and oriented department able to pursue member demographics in traditional ways such as through the PCP office and FSD, but also through other resources.

Reasons for Referral to Case Management -
Percentage

100%
80%
60%
40%
20%
0%

3Q07   4Q07   1Q08   2Q08

Legend:
- Mental Health Subcontractor
- Adult
- Asthma
- Lead
- Pediatrics
- High Risk OB
- Therapy

Source: Navcare Case Mgt System
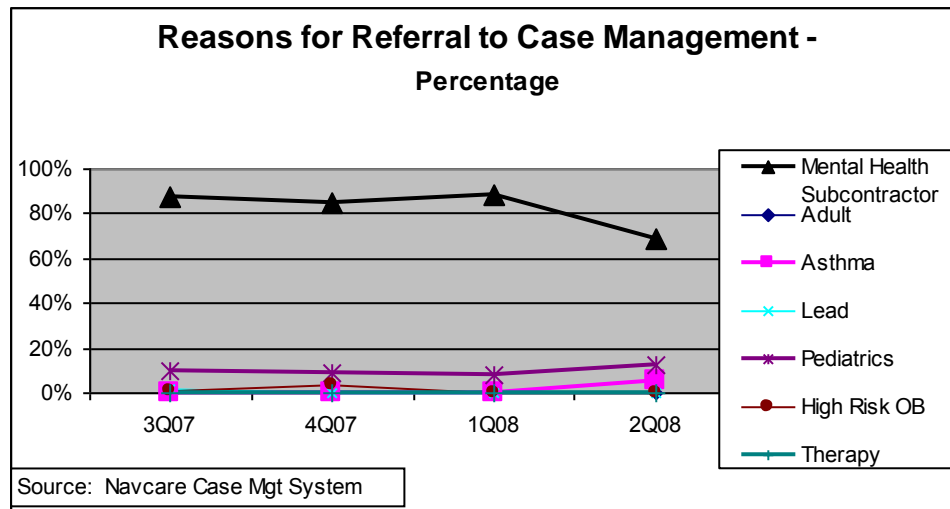
The highest rate of referrals to case management was to the mental health provider, followed by pediatric medical referrals and asthma.

Preauthorization

One of the most important elements in managed health care is the presence of the authorization system. It is this system that provides a key element for medical management in the delivery of medical services. There are multiple facets to an effective authorization system. Preauthorization is defined as the review strategy that helps determine appropriate utilization before care is delivered. The process also includes obtaining demographic and clinical information from the requesting provider and entering the information into the database. The distinct advantage of preauthorization is that it allows intervention prior to the delivery of patient care and services.

The Preauthorization Department is supervised by a Missouri licensed Registered Nurse and is comprised of eight (8) Missouri licensed nurses who are responsible for performing medical necessity review as compared to InterQual criteria or Coventry technical specifications for new medical technology and new uses of existing medical technology for services requested that require preauthorization. Each case is also reviewed to determine if complex case management or disease management intervention is appropriate.

There are nine primary goals of the preauthorization process that include:
- Member eligibility is verified and benefit coverage is determined.
- Provider eligibility is verified and verification that services are provided by an appropriate contracted provider.
- Authorized services are medically necessary and provided at the most appropriate level. Preauthorization Coordinators utilize InterQual standardized criteria, clinical judgment and the Medical Director to assure that all authorized services are medically necessary and appropriate. If a case reviewed by preauthorization staff does not meet InterQual criteria, it is referred to a Medical Director for review.
- Concurrent Review is notified that a member has been admitted as an inpatient. The Concurrent Review Nurse will begin reviewing the member's medical record to assure each inpatient day is medically necessary and appropriate for an inpatient level of care as

compared to InterQual criteria. Cases not meeting InterQual criteria for level of service and intensity are referred to a Medical Director for review.

- Cases are identified for which a Complex Case Management or Disease Management evaluation is appropriate. The Preauthorization Coordinator can assist in assuring that members with complex and ongoing medical needs are appropriately referred for evaluation of needs for more intense medical management.
- Discharge planning is begun as soon as possible when preauthorizing elective inpatient admissions. This is the ideal time to identify the discharge plan, anticipated barriers to timely discharge, and any projected services required upon discharge (home care, durable medical equipment, skilled nursing care).
- The care takes place in the most appropriate setting. A request for inpatient services may be diverted to an ambulatory care setting, or a case may be diverted from a nonparticipating provider to a participating one.
- Data is captured for financial accruals and utilization reporting. By identifying the number and nature of hospital cases, as well as potential catastrophic cases, the Plan can more accurately predict expenses rather than waiting for claims to come in. This allows management to take action early and to avoid financial surprises. It is also the time to identify those members who have (or can be expected to) incur high-dollar costs. For reinsurance purposes, the costs must be tracked and reported to insure appropriate reimbursement.
- Quality of care issues are identified and reported appropriately.

In support of the Preauthorization Department, two non-clinical personnel fill the roles of Preauthorization Representatives. The Preauthorization Representatives support the preauthorization staff by taking on tasks that do not involve clinical expertise or knowledge. They work under the supervision of the pre-authorization team leader and manager of the department. These staff do not conduct any UM review or activities that require interpretation of clinical information.

The Preauthorization Representatives serve as support for the Health Services Department by faxing information and assisting in department mailings to providers and members. They enter data into the referral system that consists of:

- Demographic information for large hospital groups.
- Newborn authorizations, which consist of statistical data
- Home health authorization for the mom and baby.
- Global referrals to cover the member prenatal care, as well as home health authorization for selected vendors.

Mental Health

MHNet and Healthcare USA have procedures in place for coordinating care for members with co-morbid issues. MHNet contacts Healthcare USA complex case managers or disease managers when a member is receiving psychiatric services who is pregnant or has complex medical issues that without proper coordination could result in negative treatment outcomes. Healthcare USA also communicates to MHNet if a members receiving medical treatment is identified as having behavioral health needs.

Quality and cost benefits have been shown to occur when social workers address issues such as adherence, psychosocial factors, and depression in terms of patients' global recovery and concurrent enhancement of quality of life. Evidence-based methods of evaluating health care outcomes, as well as quality of life issues are areas that social workers have traditionally been concerned in acute care settings, but more recently have expanded this skill to managed care, including HealthCare USA in 2008.

Social work practice with case management and disease management populations in our health plan focus on the life stressors of children, adults and their caregivers, assess high-risk patients and families, support caregivers, provide financial counseling, advocate within the medical system, resolve social and environmental issues, connect families to resource networks, and intervene when anxiety and depression are present. All of these roles reflect the specialized training of social workers in health care environments. As a new participant and member of the interdisciplinary team, The social worker at HealthCare USA helps with the psychosocial management of chronic diseases to help get and keep children at school and adults at work

In FY 2008, MHNet and Healthcare USA continued collaborating to enhance the referral process for members, particularly for Children with Special Needs and High Risk OB cases, to improve efficiency and coordination of care. Enhancements started with monthly joint meetings with care management staff from MHNet and HealthCare USA in which processes and specific cases are discussed. MHNet staff were also available during weekly HealthCare USA case and disease management and grand rounds for cases involving behavioral health issues. An opportunity to increase communication and collaboration by co-locating an MHNet case manager with HCUSA staff was identified. Co-locating and establishment of one key person for daily on-going coordination between behavioral health issues managed by MHNet, HealthCare USA's Social Worker and other HealthCare USA Health Services staff was implemented third quarter of 2008.

Dental

HealthCare USA and Doral partnered on a variety of coordination of care activities and community events in CY 2007 - June 2008:

- HealthCare USA sponsored back-to-school health fairs in 2007, in which Doral provided dental hygienists that performed dental screenings on more than 1,500 children. Doral also provided toothbrushes, toothpaste, oral health literature and stickers for distribution at the fairs.
- Participation in the Washington County Health & Wellness Outreach project in collaboration with the Missouri Oral Health Preventative Services Program. Doral provided hygienists for multiple screening dates in November 2007 and provided toothbrushes, toothpaste, oral health literature and stickers as well.
- Our outreach programs traveled to various schools and head start programs throughout the state of Missouri providing oral health education, toothbrushes, toothpaste and oral health literature.
- Participated in the Operation Breakthrough Varnish Event in February, 2008 in coordination with HealthCare USA and the PSP program. Doral provided dental hygienists that performed dental screenings, volunteers to assist with fluoride application and oral health education.

- Participated in Child Advocacy Day at the Capitol. Doral distributed toothbrushes, toothpaste, and oral health literature.
- Member Placement Program to assist in securing dental appointments for HealthCare USA members.

Case Management
Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs using communications and available resources to promote quality, cost-effective outcomes – Commission for Case Manager Certification (CCMC).
The goal of complex case management is to eliminate barriers care and services and encourage appropriate use of health care services on a case-by-case basis.

In FY 2008, the Case Management Program continued to be an integral part of HealthCare USA's individualized, member-centered approach to meet our members' medical and psychosocial needs. The case managers are Missouri licensed nurses who serve as member advocates. HealthCare USA has nurse case managers who have appropriate clinical experience and an understanding of the health needs of the MO HealthNet Managed Care population in all three regions. They coordinate services provided through the health care delivery system and community-based organizations to achieve optimal member outcomes.

At the start of 2007, case and disease management were more clearly defined and stratified, resulting in a decline in the amount of members in case management.

Frequency of Diagnoses for Case Mgt
Members 21 and Older

Count of Diagnoses for Case Mgt
Members 21 and older
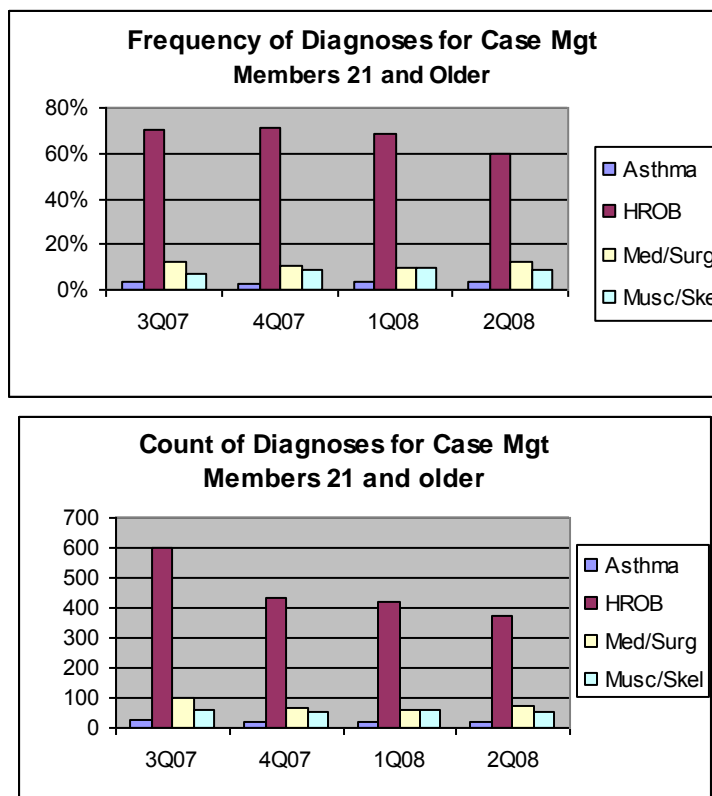
For members 21 years of age and older, the highest frequency diagnosis is high risk OB, consistent with the general membership population. The volume decreased from 3Q07 through 2Q08 due to the stratification of HROB population to case management and disease management.

Frequency of Diagnoses for Case Mgt
Members less than 21 Years of Age

Count of Diagnoses for Case Mgt
Members less than 21 years of age
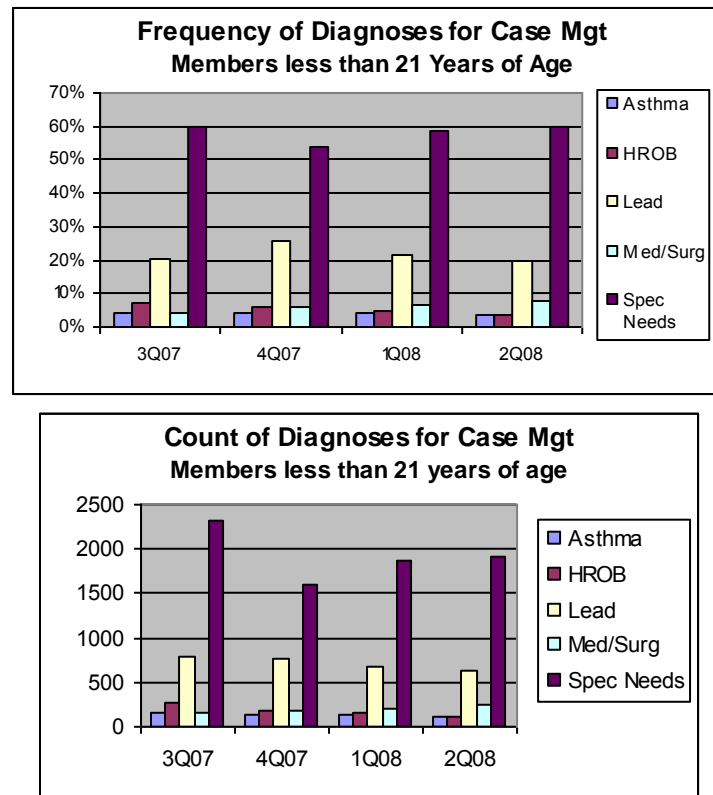
Special needs is the largest volume diagnosis for members less than 21 years of age, with lead case management the second most frequent. This has remained consistent throughout FY 2008.

HealthCare USA strongly support the concept that quality of care cannot be compromised for the sake of cost reduction. HealthCare USA has both an ethical and legal responsibility for clinical excellence. Our Case Management Program is designed to assure cost-effective, high-quality care and services.

All interventions listed below continued to play an active role in the case management program.
- HealthCare USA takes an aggressive approach to identify members. Methods include:
  o Self-referrals
  o New member calls
  o Health risk assessments
  o Member surveys
  o In-patient certification review
  o Providers
  o HealthCare USA's pharmacist, pre-authorization staff and member advocates.

- o Claims and utilization data analysis to detect trigger diagnoses such as cancer drugs, hospital readmission with in thirty (30) days or less, multiple hospital admissions for same diagnosis, chronic conditions and authorizations for high dollar DME.
- Implementation of a case management database to track and report data
- Initial telephonic needs assessment that includes a broad range of questions to determine individual situations and risks. Areas assessed are physical and mental health, social and emotional status, capability for self-care, member goals and current treatment plans.
- Individualized treatment plan development based on the assessment.
- Collaboration with the PCP to ensure plans of care support the medical plans.
- Consideration of needs for social, educational, therapeutic and other non-medical services such as WIC, Catholic Charities, Nurses for Newborns, counseling and the strengths and needs of the entire family.
- Development of member and provider educational materials.

Disease Management Program
Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. – Disease Management Association of America. The goal of disease management is to prevent exacerbations and/or complications related to specific diagnoses.

Asthma

The mission of the asthma disease management team is to improve the quality of life and outcomes of care for HealthCare USA members with asthma through education and collaboration with members, providers and community resources. HealthCare USA has actively managed the asthma population since 2005, in a case/disease management model. In 2007, the program was changed to stratify the asthma population to identify those individuals with a lower acuity from those with a higher acuity, that are most likely to incur adverse outcomes. The program is designed to provide more intense interventions for those at greatest risk for exacerbations.

The asthma disease management staff are State-licensed registered nurses with past clinical experience in caring for patients with asthma. Their vision is that every HealthCare USA member with asthma will live a normal life without any limitations from asthma. Their guiding principals are:
- Work proactively and collaboratively with communities and providers.
- Encourage responsibility and investment on the part of the member to ensure wellness.
- Incorporate measurable outcomes and objectives in health improvement.
- Ensure strategies draw from and compliment our mission.
- Align structure and incentives.
- Manage health and financial risks.

The HealthCare USA goals for the asthma disease management program are:
- Reduce health care costs associated with asthma by reducing asthma related hospitalizations and ED visits
- Improve quality of care and self-management skills as evidenced by:

- o Improved HEDIS measure for appropriate asthma medications.
- o Improve quality of life and well being as evidenced by member reported improved ability to self-manage and health status as reported on satisfaction survey & HRA.
- o Improve member, provider and staff satisfaction with the asthma Disease Management process and services.
- Set a new all time best standard for asthma outcomes across Coventry

The asthma disease managers perform telephonic and face-to-face education and utilize community resources in the management of these members. The National Heart Lung Blood Institute (NHLBI) National Asthma Education and Prevention Program (NAEPP) clinical practice guidelines are referenced for ongoing member and provider education. They manage both the adult and pediatric population, however approximately 98% of the population is pediatric.

The disease managers utilize multiple resources to assist these members. Some of the resources utilized are:
- Community based programs such as the Asthma and Allergy Foundation, the American Lung Association, the St. Louis Asthma Consortium, the Community Asthma Program, and Health Kids Express.
- School nurses are also an important resource for community collaboration.
- Pharmaceutical company donated spacers and peak flow meters are provided at no cost to providers and other community resources verbalizing a need.
- Partnership with the Human Development Corporation has provided the Community Action Voicemail Service at no cost for our members who do not have access to telephone service.
- Completion of nursing intense member education materials

Since the implementation of asthma care activities and initiatives, HealthCare USA has achieved improvements for members in all regions.

Asthma-ED Visit Rate
Data Source: Coventry CDW

Goal: Decrease ED visits by 2%. Asthma related ED visits decreased from 26.4 per thousand in 2006 to 21.9 in 2007, a 17% decrease from baseline. There has been a 12.4% reduction from 2007 to 2008 YTD. HCUSA ERG score 2007: 0.9072 2008 YTD Sept. 0.9730.

Rate of ED Frequent Flyer visits for Diagnosis of Asthma
Data Soruce: MET Cube

- Central
- Eastern
- Western
- All

Six Months Ending....

Rate of members with 3 plus ED visits for the primary treatment of asthma has continued to decrease since Nov. '07.

Asthma 90 Day Readmission Rates 2006-2008 (June)
Data Source: Coventry CDW

- Overall Reamission Rate
- Pediatric Readmission Rate
- Adult Readmission Rate
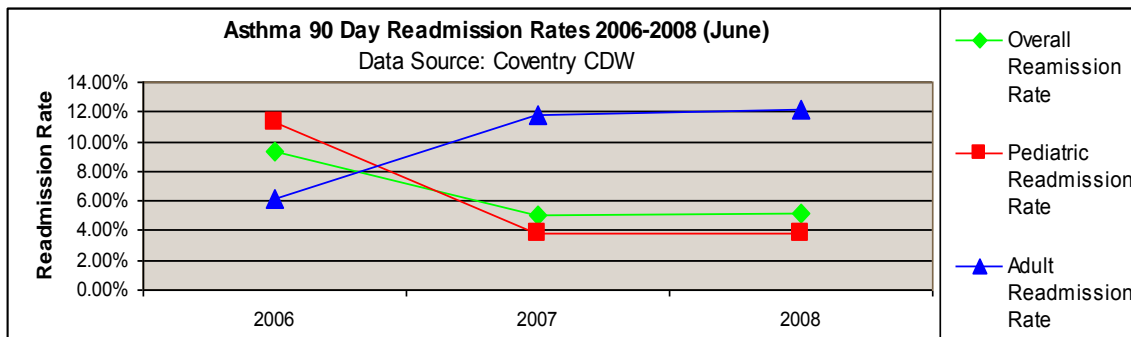
Goal: Decrease readmit rates by 2%. Overall asthma related readmissions within 90 days improved 0.45% from the 2006 baseline to 2007 year end.

Asthma Disease Management Morbidity Assessment Outcomes
January-Oct 2008
Data Source: HCUSA Asthma Morbidity Assessment Database

- URI
- Non-Adherence
- TxPlan Failure
- No Action Plan
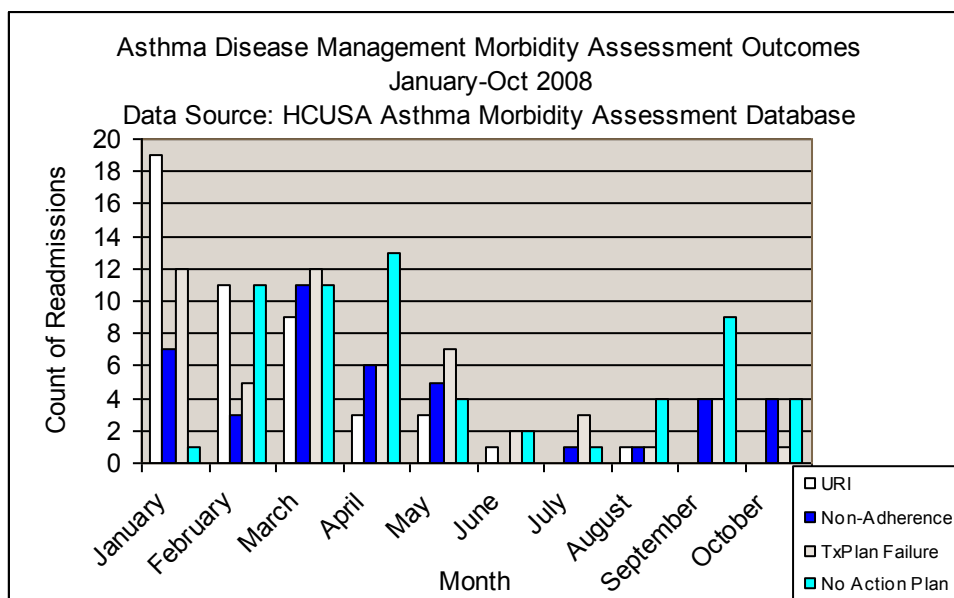
Morbidity assessments are performed on those members enrolled in asthma disease management who are admitted to the hospital. The goal of completing these assessments is to identify any actionable trends in reasons for admission. Upper respiratory infection has been the primary reason/identifiable component for readmission. There has been no trend in those with respiratory infections having evidence of poor asthma control prior to the infection/admission.

Use of Appropriate Meds with Asthma Dx
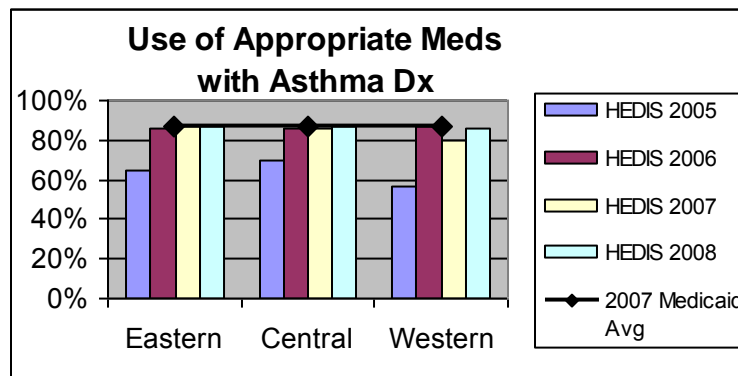
The HEDIS measure ―Use of Appropriate Medications with a Diagnosis of Asthma" is at the 2007 MO HealthNet average for all 3 regions. HealthCare USA uses within year HEDIS datasets of those members numerator non-compliant to call and remind and assist them, if needed, in filling their asthma prescriptions.

Asthma Med Refills of DM Members
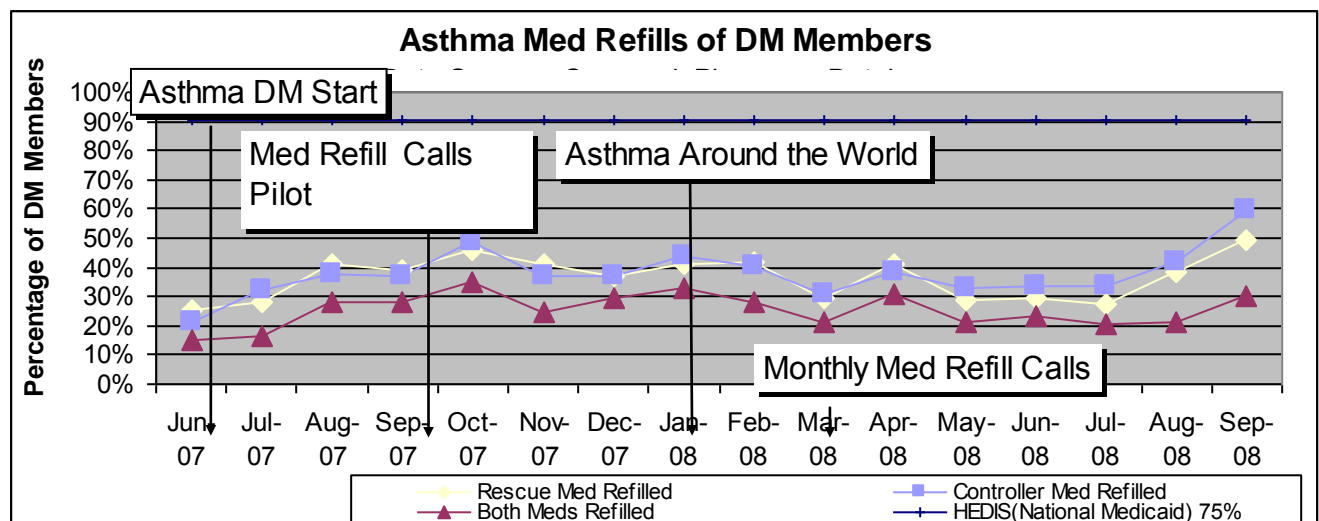
Goal: Increase adherence with asthma medication refills. DM program participant adherence to asthma medications (including refills)increased from 15% June, 2007 to 21% June, 2008, and all asthma medication costs 7.6%, from 3.96 PMPM to 4.26PMPM. Asthma-related outpatient visits per thousand increased from 2207 per thousand in 2006 to 3604 in 2007, a 40% increase in primary care

High Risk OB

The mission of the high risk ob disease management team is to work in tandem with providers, the community and High Risk OB members to increase the number of healthy moms and full term babies. Since 1995, HealthCare USA has improved care for members with high-risk pregnancies through the multi-disciplinary high-risk OB case management program. In 2007, HealthCare USA developed this into a disease management program, further enhancing the services provided to members with the greatest risk of poor outcomes related to preterm labor and delivery.

The high risk OB disease management staff consists of four (3) State-licensed, experienced obstetrical registered nurses. Their vision is to improve the health of mom's and babies by eliminating preterm labor and delivery, and the complications associated with preterm delivery. Their guiding principals are:
- Work proactively and collaboratively with communities and providers.
- Encourage responsibility and investment on the part of the member to ensure wellness.
- Incorporate measurable outcomes and objectives in health improvement.
- Ensure strategies draw from and compliment our mission.
- Align structure and incentives.
- Manage health and financial risks.

Goals of the high risk OB program:
- Reduce the number of NICU admissions
- Reduce the number of preterm deliveries and complications and mortality associated with preterm delivery
- Improve member, provider and staff satisfaction with OB disease management process and services
- Reduce the cost of ED visits and hospitalizations for high risk OB members
- Be the leader in OB disease management services for Coventry

HealthCare USA identifies members for high risk OB disease management based on the following indicators:
- istory of preterm delivery of preterm labor
- Gestational diabetes, uncontrolled diabetes
- Hypertension
- HELLP syndrome
- Incompetent cervix
- Multiple gestation
- Placenta abruption/previa
- PIH/pre-eclampsia
- ≥22 weeks uncontrolled vomiting
- ≥22 weeks ≤37 weeks and admitted to hospital
- Hyperemesis due to organic disease
- Previous neonatal death ≥22 weeks ega
- Sickle-cell/Hb-C disease with crisis
- ≤17 years of age
- Poor weight gain
- Intrauterine growth retardation
- Oligohydramnios
- Spontaneous premature rupture of membranes
- Thromboembolic disorder
- Vaginal bleeding ≥22 weeks
- Adrenal gland disorders
- Lupus

Members are referred to the high risk OB disease management through global OB requests, provider referrals, UM staff , claims review and self referrals. The staff review member clinical and authorization history to determine enrollment into the program. Individualized care plans are developed with appropriate interventions and goals. Telephonic education and coordination of services are completed in collaboration with PCPs, OBs, HealthCare USA Medical Directors and community resources.

All Live Births by Birth Weight =>2500g
Data Source: HCUSA Delivery Outcomes Database

- BIB Incentive Start
- HROB Program Start
- Peer to Peer Baby Shower

Legend:
- 2500+ gm Mo Avg ('03-'05)
- All 2500+
- 2500+gm DM
- 2500+gm Non-DM

X-axis: 2007 Q1, 2007 Q2, 2007 Q3, 2007 Q4, 2008 Q1, 2008 Q2
Y-axis: Percentage of All Live Births (0.00% – 100.00%)
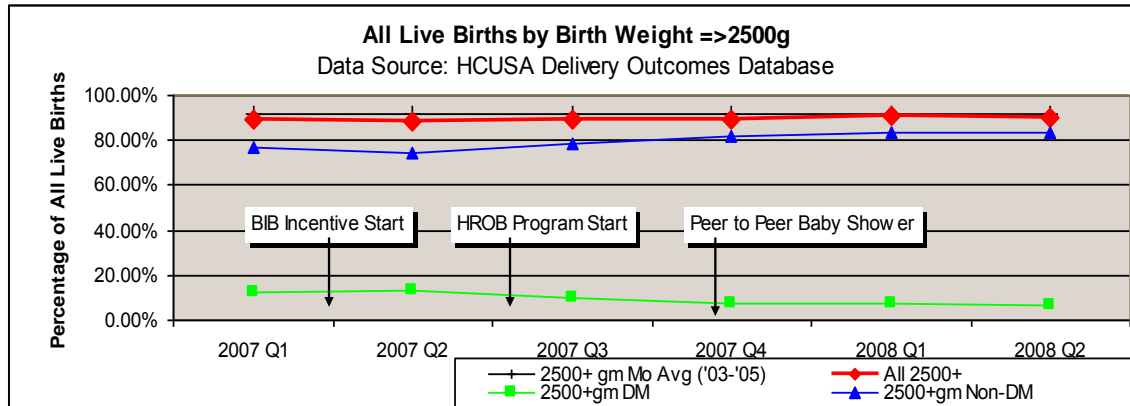
HROB DM = Beary Important Bundle (BIB) High Risk OB (HROB) Disease Management (DM) Program. Goal: Increase % of births =>2500g   Avg 2007 Birth Weight-3209.63 grams Avg

All Live Births by Birth Weight <2500g NonDM
Data Source: HCUSA Delivery Outcomes Database

Legend:
- NonDM <500
- NonDM 500-1100
- NonDM 1101-1499
- NonDM 1500-1999
- NonDM 2000-2499

X-axis: 2007 Q1, 2007 Q2, 2007 Q3, 2007 Q4, 2008 Q1, 2008 Q2
Y-axis: Percentage of All Live Births (0.0% – 7.0%)
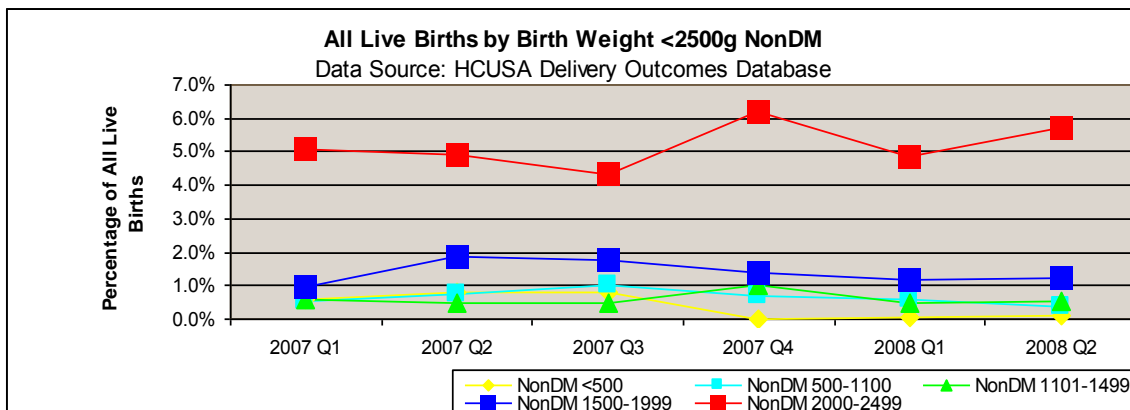
For members who did not participate in HROB Program, the percent of infants that born weighing 2000 - 2499 grams increased from 5.0% to 6.0% between Q2 2007 - Q2 2008. High risk population stratification was started in Q2 2007.

Live Births by Birth Weight <2500g in HROB DM Program
Data Source: HCUSA Delivery Outcomes Database

Legend:
- DM <500
- DM 500-1100
- DM 1101-1499
- DM 1500-1999
- DM 2000-2499

X-axis: 2007 Q1, 2007 Q2, 2007 Q3, 2007 Q4, 2008 Q1, 2008 Q2
Y-axis: Percentage of All Live Births (0.0% – 2.0%)
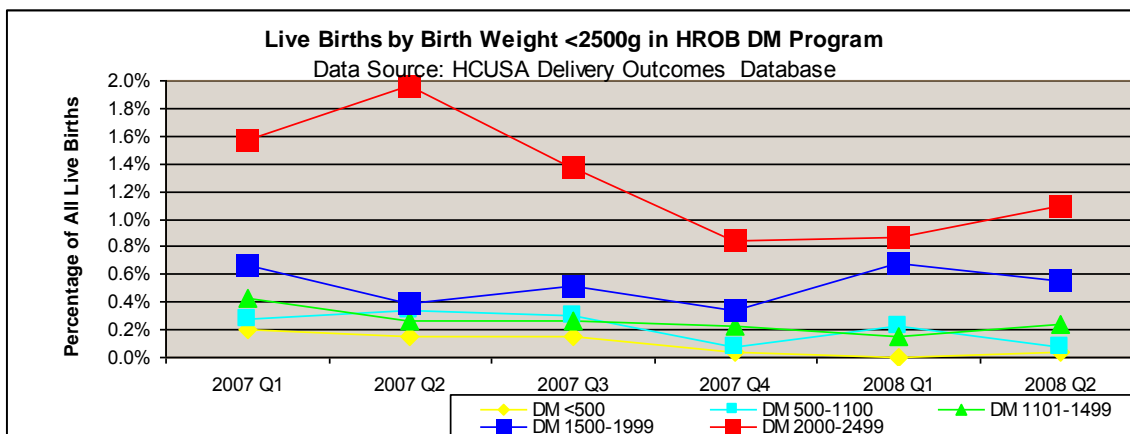
For members who did participate in HROB Program, the weight in grams at birth has been trending upward for all subcategories, except those born at 1100 grams and less, which has been declining since Q4 2007. Population stratification to identify those members at highest risk for poor birth outcomes was started in Q2 2007.

All Live Births by Gestational Age- =>37 Weeks Gestation
Data Source: HCUSA Delivery Outcomes Database

Legend: All 37+ Weeks GA; Non-DM 37+ Weeks GA; DM 37+ Weeks GA; 37 Wks Mo Avg ('03-'05)

Annotations: BIB Incentive Start; HROB Program Start; Peer to Peer Baby Shower
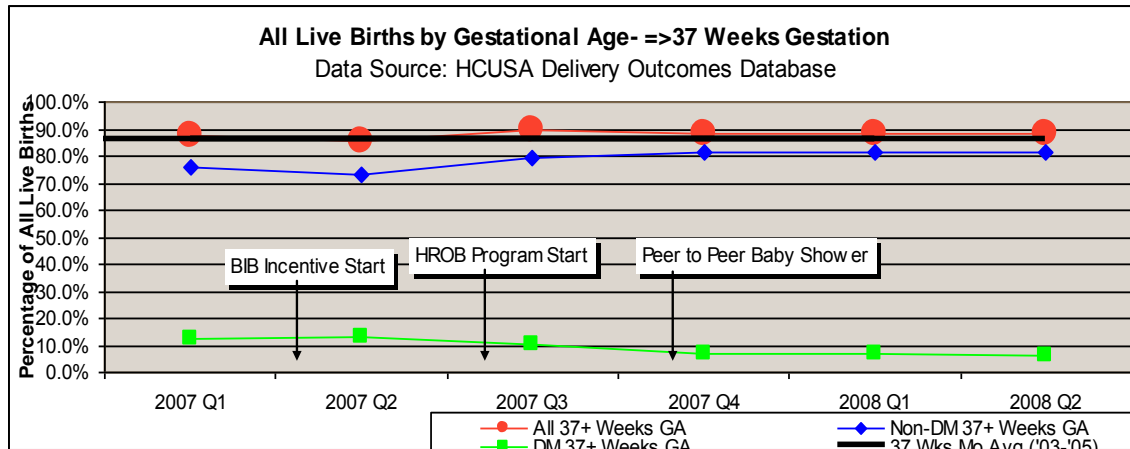
BIB HROB DM Program Goal: Increase % of births > 37 weeks gestation   Avg Gestational Age 2007 - 38.9 weeks Avg Gestational Age 2008 YTD - 39.0 weeks, <1% change

Live Births by Gestational Age-< 37 Weeks Gestation in HROB DM Program
Data Source: HCUSA Delivery Outcomes Database

Legend: DM <22 Weeks; DM 22-25 Weeks; DM 26-29 Weeks; DM 30-36 Weeks
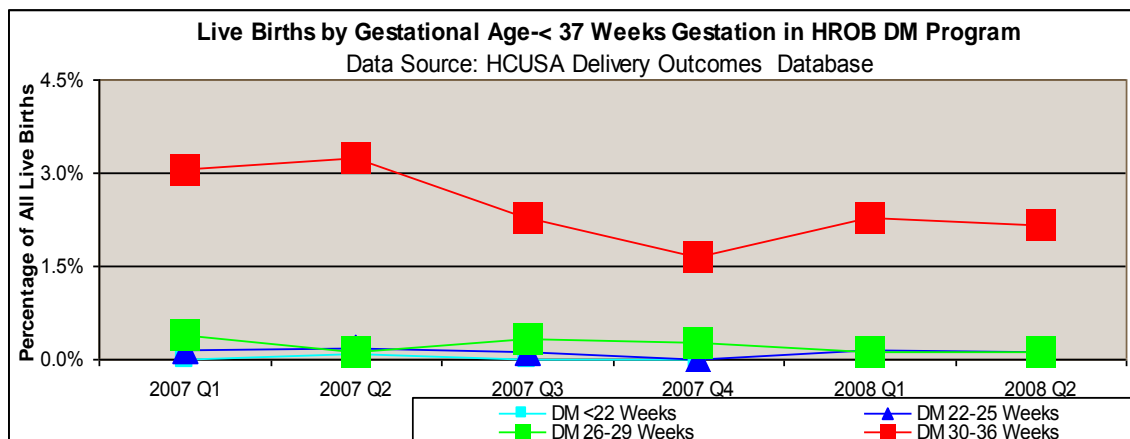
Goal: Increase average gestational age at birth. BIB HROB DM Program participant Avg Gestational Age at birth 30-36 weeks decreased initially with implementation of member risk stratification and has trended upward since Q4 2007. 26-29 completed weeks gestation has decreased slightly; 22-25 has increased slightly; less than 22 weeks decreased, but is subject to variation as a percentage of all due to small number.

Live Births by Gestational Age-< 37 Weeks Gestation NonDM
Data Source: HCUSA Delivery Outcomes Database
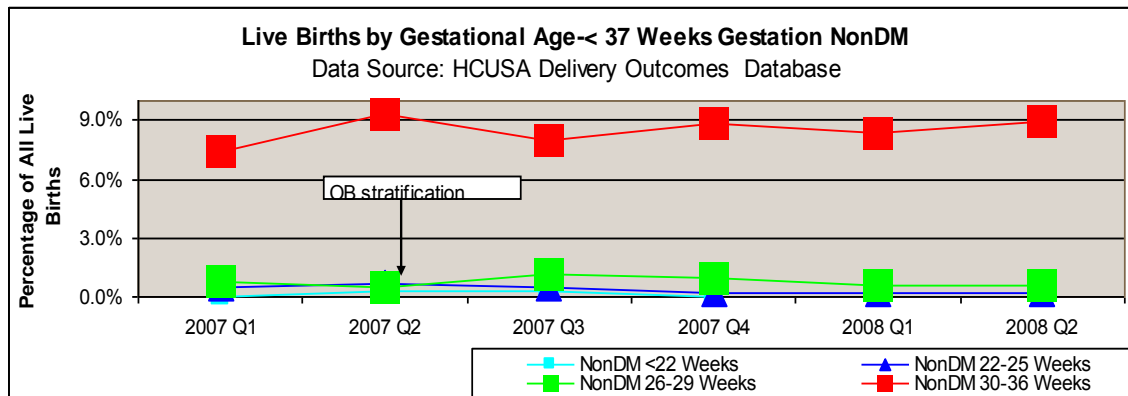
Non HROB Program participant Avg Gestational Age at birth 30-36 weeks increased from 6.5% to 9.0% ; 26-29 weeks decreased slightly and 22-25 weeks has remained essentially unchanged; less than 22 weeks decreased but is subject to variation due to the small number.
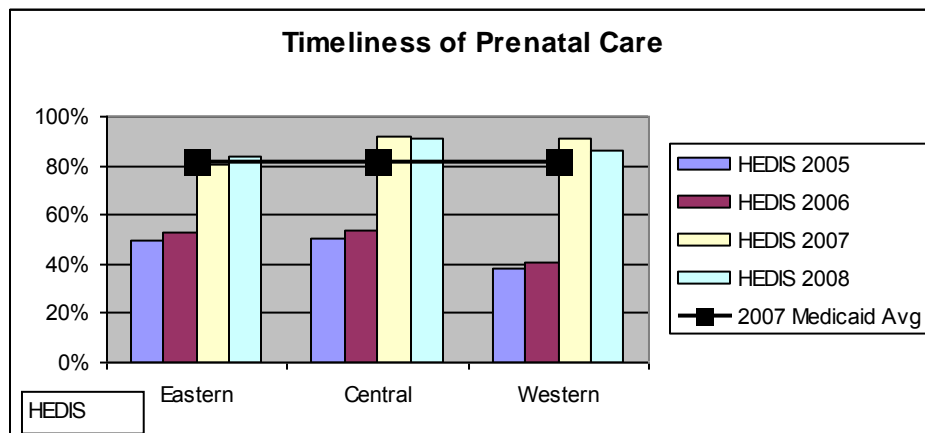
For the HEDIS indicator ―Timeliness of Prenatal Care" has remained at or above the 2007 MO HealthNet average for the past 2 years. Western region saw a decline from HEDIS 2007. This is partially reflection of the acquisition of the FirstGuard health plan's membership in the Western region and delays in start of prenatal care.

In 2008, HealthCare USA's High Risk OB Task Force identified an opportunity to improve appropriate utilization per ACOG statement for clinical guidelines and tracking of 17P Alpha-hydroxyprogesterone. Candidates are more aggressively identified and there is increased collaboration with the member's OB healthcare provider and the high risk OB disease manager. HealthCare USA is using a database to track all outcomes, and is identifying changes in outcomes and their significance.

2008 17P Census Tracking (January 2008 through September 2008)
Data Source: HCUSA 17P Database and Coventry CDW

Legend:
- Current Patients
- New Patients
- Patients who Delivered
- No 17P Received
- Total Qualifying Candidates
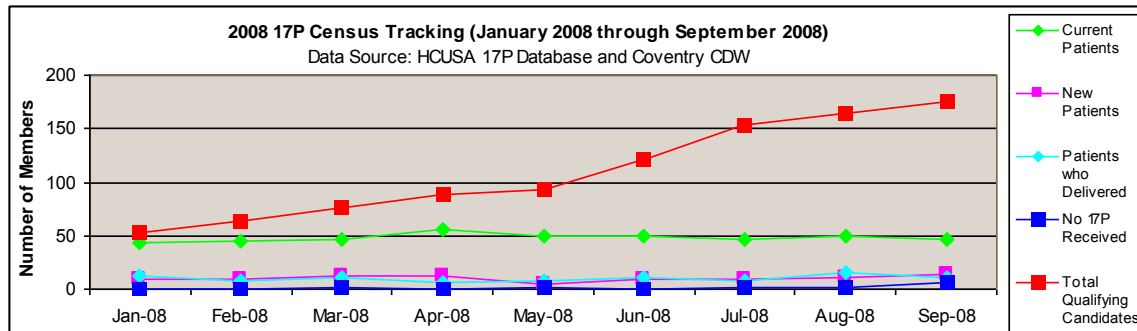
The number of members identified as having had a previous preterm birth has increased from approximately 50 in the prior year to well over 150 YTD, 2008. When a member is identified as potentially qualifying, a letter is sent to the member's OB including the process for obtaining prior authorization for 17P.

Previous Delivery vs. Current with 100% Adherence to 17P Protocol
Data Source: HCUSA 17P Database

Legend:
- GestationalAgeAtBirth
- Previous Pre-Term Delivery Gestation
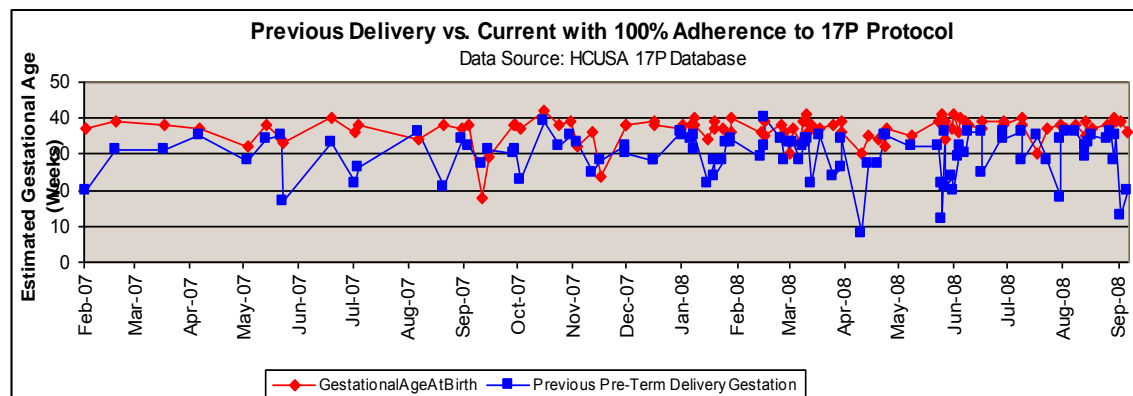
Mean gestational age in weeks increased from prior birth ~3.67 - 8.2 weeks with 17P. Deliveries without recorded gestational age at birth omitted. (Through June '08: CI 95% with T test; p=0.000 Pearson Chi Square p= 0.0000005 Fischer's Exact Test.)

Previous Pre-term Delivery vs. Current with No 17P
Data Source: HCUSA 17P Database
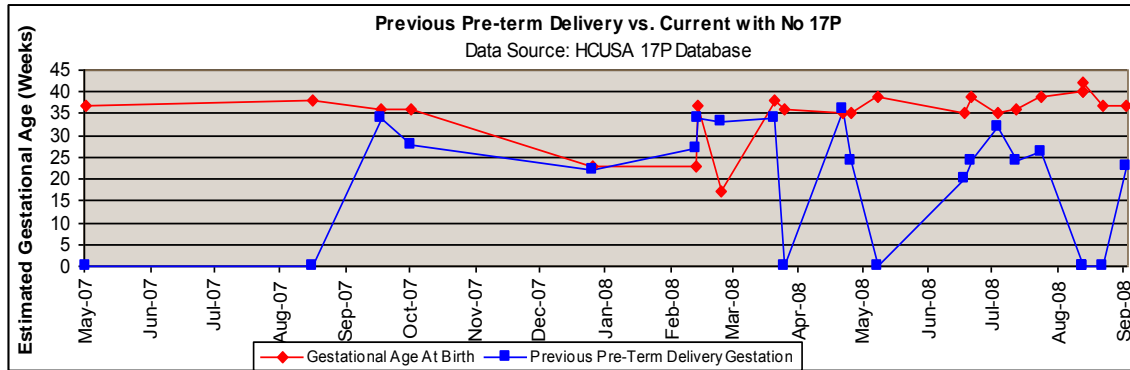
Current deliveries with a prior preterm birth history that do not receive any 17P, mean gestational age is 5.551 weeks earlier than those with 100% adherence to 17P protocol. (end of June '08 p=0.00; Mann-Whitney and Two Sample T-test; coef= 1.952)

Previous Delivery vs. Current with <50% Adherence to 17P Protocol
Data Source: HCUSA 17P Database
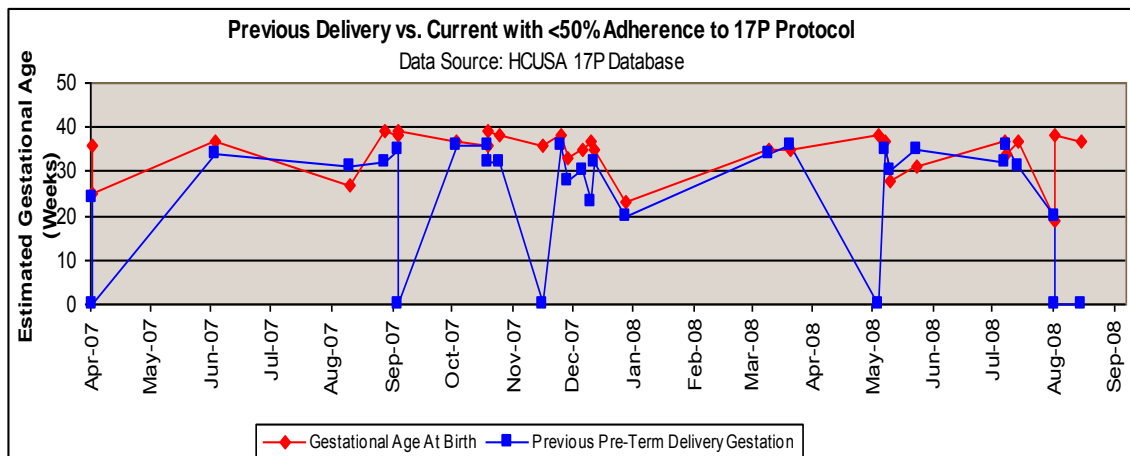
Current deliveries (through June-08) who received at least one but not more than 50% of 17P injections ordered mean gestational age was decreased by 5.748 weeks as compared to those who had 100% 17P adherence. (Up to end June '08- Pearson ChiSquare p=0.01 ; Mann-Whitney and Two Sample T-test for significant difference;)

Mental Health Care Management including Case Management

MHNet continued the Quality Improvement Project, Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness (see Performance

Improvement Projects – Clinical). Results of the QIA are clearly seen in the HEDIS rates for Follow-up after Hospitalization for Mental Illness; however, MHNet includes all members (including those not meeting HEDIS inclusion criteria) in discharge planning activities.

MHNet continues to focus on ambulatory follow-up and dedicate significant case management resources to improving follow-up rates. Efforts include a clinician dedicated exclusively to discharge planning activities and outreach to all inpatient facilities to encourage the facilities to partner with MHNet in securing follow-up appointments for members.

Family Evaluation/Therapy for Adolescent/Child Members – Mental Health
MHNet continued to actively advocate family therapy for children and adolescences through educational outreach efforts to providers and members. MHNet's Practitioner Newsletter for 2006 and 2007 included an article promoting family therapy. MHNet also has a fax back initiative for providers who submit Outpatient Treatment Records requesting individual versus family therapy for treatment of a child less than 18 years of age. This initiative requests the provider to explain the rationale for individual therapy versus family therapy and allows for an additional educational outreach advocating for family therapy.

MHNet's customer service and case management process also emphasizes family therapy with initial referrals and authorizations supporting a combination of individual and family sessions for members under eighteen (18). MHNet educates providers regarding the use of CPT codes that reflect the actual level of family involvement and other issues.

Clinical Practice Guidelines
The QMC approved several new and updated clinical practice guidelines to be followed by HealthCare USA and the provider network. A summary of the guideline and links to these guidelines can all be found on the HealthCare USA provider website. The following grid lists the guidelines, the organization who created them, who at HealthCare USA reviewed the guidelines and date of approval by the QMC.

Guideline	Organization	Guidelines Reviewed By:	Date of QMC Reviews
17-P	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008
ADHD-Diagnosis and Evaluation of the Child with ADHD	American Academy of Pediatrics (AAP) Clinical Practice Guidelines *May 2000* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Asthma Management	KCQIC Guideline Adopted from the National Institute's of Health: National Heart, Lung and Blood Institute's Guidelines for the Diagnosis and Treatment of Asthma *December 2007* *(www.nhlbi.nih.gov/guidelines/asthma/index.htm)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 November 2007 March 2008 December 2008
Bipolar Disorder	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Bipolar Disorder *1994*	HealthCare USA Staff Members HealthCare USA Medical	March 2007 December 2008

		Director QMC Committee	
Bronchiolitis-Diagnosis and Management	American Academy of Pediatrics Clinical Practice Guidelines *October 2006* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Chlamydia Screening and Treatment	California Chlamydia Action Coalition; CA Department of Public Health *March 2007* *(www.std.ca.gov)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
COPD Management	Global Institute for Obstructive Lung Disease *June 2006* *(www.goldcopd.com)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Depression, Major	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Major Depression *April 2000* *(www.psych.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Diabetes Management	American Diabetes Association; Standards of Medical Care in Diabetes *January 2008* *(www.dhss.mo.gov/diabetes/guidelines.html)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 December 2008
Eclampsia and Pre-eclampsia- Evaluation and Treatment of	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008
Diabetes-Gestational	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008
Heart Failure Management	KCQIC Guideline Adopted from American Heart Association and American College of Cardiology *July 2006* *(www.medscape.com/viewarticle/520123)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 December 2008
Hyperlipidemia-Diagnosis and Management	KCQIC Guideline Adapted from American Heart Association; National Cholesterol Education Program; National Institute of Health *June 2007* *(www.NIH.gov)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	December 2008
Hypertension (Essential) Management	KCQIC Guideline adopted from Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure *August 2006* *(www.nhlbi.nih.gov/guidelines)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 December 2008
Immunizations-Adult Recommended Schedule	Centers for Disease Control (CDC) *January 2008* *(www.cdc.gov)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 November 2007 December 2008
Immunizations-Child Recommended Schedule	Centers for Disease Control (CDC) *January 2008* *(www.cdc.gov)*	HealthCare USA Staff Members HealthCare USA Medical	March 2007 March 2008 December 2008

		Director QMC Committee	
Lead Exposure in Children: Prevention, Detection and Management	American Academy of Pediatrics Clinical Practice Guidelines *October 2005* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Obesity-Identification, Evaluation, and Treatment of Obesity in Adults and Children	KCQIC Guideline Adapted from National Heart Lung and Blood Institute(NHLBI) Obesity Education Initiative *November 2004* *(www.ama-assn.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 December 2008
Otitis Media-Diagnosis and Management	American Academy of Pediatrics Clinical Practice Guidelines *May 2004* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Pregnancy Management – Prenatal and Postnatal	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Preterm Birth-Assessment of Risk Factors	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008
Preterm Labor	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008
Preventative Adult Health Care (18-49 years)	Centers for Disease Control (CDC) *October 2007* *(www.cdc.gov)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	December 2008
Preventative Adult Health Care (50-65+ years)	Centers for Disease Control (CDC) *October 2007* *(www.cdc.gov)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	December 2008
Preventative Pediatric Health Care Recommendations (EPSDT)	American Academy of Pediatrics Clinical Practice Guidelines *March 2008* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Schizophrenia	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Schizophrenia *April 2004* *(www.psych.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008

Substance Abuse Disorders	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Substance Abuse Disorders. *August 2006* *(www.psych.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Synagis-Guidelines for Coverage	American Academy of Pediatrics Clinical Practice Guidelines *January 2006* *(www.aap.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	March 2007 December 2008
Tobacco Control	KCQIC guidelines adopted from the Institute for Clinical Systems Improvement (ICSI) Tobacco Use Prevention and Cessation for Adults and Mature Adolescent; American Lung Association *December 2005* *(lungusa.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	September 2006 March 2007 December 2008
Vaginal Birth After Cesarean Delivery (VBAC)	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff Members HealthCare USA Medical Director QMC Committee	July 2007 December 2008

Credentialing and Re-Credentialing
HealthCare USA has the sole right to determine which primary and specialty practitioners it shall accept and retain as HealthCare USA providers. The Credentials Committee, with Medical Director leadership, provides oversight of all credentialed and re-credentialed practitioners. HealthCare USA monitors the effectiveness of the credentialing program on a quarterly basis. The key indicators of this include:

- Turn around time for credentialing and recredentialing
  The average turn around time for all files was 40 days.

- Number of providers credentialed and re-credentialed for the year
  3rd Quarter 2007 – 216
  4th Quarter 2007 – 266
  1st Quarter 2008 – 319
  2nd Quarter 2008 - 387

- Number of providers who were terminated and/or de-credentialed for the year
  109 Terms

HealthCare USA conducted oversight of eleven (11) delegated credentialing entities to ensure compliance with the requirements of the health Plan and the State of Missouri. The annual audit consisted of reviewing randomly selected credentialing and recredentialing files, policies and procedures, and committee meeting minutes.

It is HealthCare USA's standard that each delegated entity achieve a score of at least 80% or greater. If issues are identified during the auditing process, clarification is requested and

corrective actions are taken should the facility be unable to comply. Audit results are presented to the Credentialing Committee and Quality Management Committee (QMC). Recommendations are made on an ―as needed‖ basis.

Of the delegated entities, 100% attained a score of 80% or greater. HealthCare USA will continue to provide oversight of its delegated entities. Currently, HealthCare USA delegates credentialing and re-credentialing to the following providers:

- BJC Medical Group
- Children‗s Mercy Health Network
- Family Care Health Center
- Mineral Area Network
- Peoples Health Center
- SSM Health Care
- St. Louis Connect Care
- Truman Medical Center
- Unity Health Services
- Washington University Physician Network
- SLUCare

Medical Record Review
HealthCare USA‗s Quality Improvement Department continues to conduct on-site medical record reviews based on the provider recredentialing list. This compliance review ensures maintenance of adequate, detailed and comprehensive medical records in an effort to improve clinical outcomes and increase patient safety. In addition, the medical record is reviewed for key indicators based on diagnosis for conformation to evidence based clinical practice guidelines.

Completeness of Record:
- Biographical information
- Patient history and family history
- Patient chief complaint
- History of present illness/chief complaint
- Assessment
- Plan of Action/Treatment
- Follow Up After Care
- Screening for high risk behaviors and lifestyle factors

Safety:
- Allergies noted (notation for allergy reactions will be added as an element in 2009)
- Review and notation of any lab results, x-ray results, and consults
- Legibility
- Comprehensive problem list
- Comprehensive medication list
- Screening for sexually transmitted diseases for those at risk

The medical record chart audit also includes indicators for use of evidence based guidelines for preventative screening and care:

- Immunizations
- Lead screening
- Lead testing
- Completeness of HCY forms for all EPSDT visits
- Appropriate utilization of medications for members with asthma
- Asthma action plan and education
- Comprehensive diabetes care, including Hba1c testing, LDL testing, nephropathy screening, retinal eye exams, and blood pressure checks
- Use of BMI calculation

In 2008 a ―claims check‖ was added to the on-site audit. This included verification of the presence of documentation for claims submitted as a way to identify potentially fraudulent behavior.

Providers were audited based on the recredentialing cycle. Panel size and claims for 2007 and 2008 were taken into account when setting up an audit. Reviewers arranged an on-site visit or requested copies of documentation be mailed to HealthCare USA. A member list was chosen from claims. A chart review tool was used to objectively score each record. In addition, all dates of service for each member were compared to the medical record. Any discrepancies were noted, and further investigation was initiated.

Any providers that did not have enough claims warranting an on-site chart audit were mailed a letter educating them on the advanced directives requirements and requesting their process for educating their patients on advanced directives. The on-site and mail audits highlighted the lack of knowledge about providers‗ responsibilities with advanced directives. HealthCare USA provides advanced directives education through the provider newsletter, through follow-up after on-site and mail audits, in the new provider orientation packets and at PMAC meetings in 2008.

After the audit is completed, the provider‗s score is tabulated which is specific to each indicator on the tool. All results from the tools are added to a database and the results are shared with the provider, the provider representative and with the credentialing staff. Results are placed in the provider‗s file.

Probably the most important aspect of the on-site audit is the opportunity to provide direct, reflective, objective education to the provider and the provider office and staff. This education includes feedback on the provider‗s strong points and areas of their charting that needs improvement. Resources that are specific to the areas needing improvement, including forms, hand-outs, links, clinical practice guidelines, are given to the provider after the audit.

All providers must meet the minimum threshold of 80 percent on their chart audit. Any provider who scored below an 80% is educated on their opportunities for improvement and provided resources for accomplishment. A re-audit occurs within 180 days. A subsequent failure after the re-audit results in meeting with the provider and office representative, the HealthCare USA provider representative, and the QI employee who completed the audit. A detailed discussion on

the failure points occurs, along with an action plan for improvement. Another re-audit then occurs 180 days after the meeting.

When the Quality Improvement Department observes exceptional documentation, it is vital to acknowledge these facilities for their efforts. HealthCare USA awards exceptional offices in each region with the Sharing the Vision for Excellence in Quality award.

Recipients of the award for 2007 audits were
- Dr. Frederick Dattel of Kansas City
- Drs. Robert Pierce, Lisa Pierce, and Brice Windsor at Fulton Family Health Associates
- Dr. Diane Rup in St. Louis.

The award included a ceremony with presentation of the award by a member of the HealthCare USA management team, a desktop award and wall plaque, and catered luncheon for the entire staff. In addition for 2007, all providers who scored a 90 percent or above received a letter from the CEO of HealthCare USA commending them on their accomplishment. These providers' accomplishment was also highlighted in a provider newsletter.

HealthCare USA annually assess the outcomes of the audits and reports the results to the Quality Management Committee and in the provider newsletter. The audits clearly highlighted areas of chart documentation that need improvement, and allowed focus education as possible.

HealthCare USA also annually assesses the effectiveness of the tool in measuring the quality and safety of the PCP's medical documentation. Possible improvements for 2009 include assessment of HCY ―missed opportunities," expanded comprehensive diabetes care tracking, and tobacco cessation counseling. In addition, the education provided to the PCP will be expanded to include the provider's HEDIS results for the previous year and more information on clinical practice guidelines, best practices, and HEDIS measures and tips for coding.

Subcontractor Monitoring
HealthCare USA maintains collaborative relationships with several entities who provide specific delegated functions in order to provide comprehensive quality services and care to the MO HealthNet Managed Care membership across the Eastern, Central and Western Missouri Regions. Within these relationships, Healthcare USA retains the authority to oversee each subcontractor for compliance with the applicable statutes, regulations, policies and procedures governing each delegated function.

During FY 2008, Healthcare USA delegated the following functions to external vendors who provide expertise in each area:

Dental Services
Doral Dental USA, LLC (Doral)   July 1, 2007 – June 30, 2008
(UM and claims processing)

Transportation Services
Medical Transportation Management (MTM)   July 1, 2007 – June 30, 2008

(Claims processing)

Behavioral Health Services
MHNet Behavioral Health, Inc. (MHNet)   July 1, 2007 – June 30, 2008
(UM, claims processing, behavioral health case management)

Pharmacy
CVS/Caremark   July 1, 2007 – June 30, 2008
(Claims processing)

Healthcare USA's process for conducting ongoing monitoring of delegated vendors includes routine committee meetings with each vendor. The Oversight Committee meetings are conducted at least quarterly or more frequently as need arises. The meetings include representatives from various departments of HealthCare USA, as well as representatives from the subcontractor. The Oversight Committee is charged with reviewing and monitoring the following for compliance with applicable MO HealthNet Managed Care requirements, applicable URAC standards, as well as state and federal regulations. Delegated vendors actively participate in QMC meetings presenting their reports and updates to projects:

- Utilization Management
- Access and Availability
- Quality Management / Quality Improvement
- Provider Complaints, Grievances, and Appeals
- Member Grievances and Appeals
- Policies and Procedures regarding each subcontractor function
- Member and Provider Satisfaction
- Coordination of Care Activities
- Member Services
- Provider Services
- Claims Processing
- Fraud and Abuse
- Member and Provider Education Initiatives
- Preventive Health Programs
- HIPAA Compliance

In addition to monitoring of the above, Healthcare USA utilizes the Oversight Committee to initiate and implement corrective actions and address opportunities for improvement with each subcontractor as needed. The oversight meetings are documented through formal agendas, sign in sheets, and minutes. The subcontractors quality improvement staff also attend and report at the HealthCare USA QMC meetings and routine care management rounds. HealthCare USA participates in MHNet's regional quality improvement committee meetings.

Healthcare USA provides additional oversight throughout the year by reviewing regular reports, materials, policies and procedures etc. required of each subcontractor. These documents are disseminated to the appropriate staff at Healthcare USA and discussed with each subcontractor via regular communication and through the formal Oversight Committee. All annual documents,

i.e. annual evaluations, program descriptions, work plans, policy and procedure manuals, disaster recovery plans, etc. are also reviewed.

Missouri Care

Provider Satisfaction

The 2007 Missouri Care Provider Satisfaction Survey yielded generally positive responses. Providers rated Missouri Care Health Plan as excellent or very good more often compared to ―all other plans in the market‖ on the following composites: Call Center/Medical Services (i.e., member services), Provider Relations, Network (i.e., availability of specialists), Utilization & Quality Management, Finance Issues (i.e., accuracy and timeliness of claims payment and dispute resolution), and Pharmacy and Drug Benefits (i.e., ease of using the formulary). Additionally, nearly 74% of providers indicated a positive level of overall satisfaction with Missouri Care.

Care Coordination

Missouri Care aims to provide comprehensive member focused medical and behavioral health services. Care Coordination program components include: fostering the concept of a medical home, providing a 24/7 nurse advice line, implementation of standardized, evidence-based clinical guidelines for decision making, case and disease management programs, and quality improvement via benchmarking, establishing performance standards and outcomes measurement.

Case Management

Missouri Care strongly believes that medical and social outcomes will improve if routine services are supported and enhanced by case management interventions that effectively address the specific needs or condition of the individual member. The Case Management Program provides, but is not limited to, the following enhancements to routine care, which are based on nationally recognized clinical guidelines and standards:

- Identification of members with complex or chronic clinical or social conditions who could benefit from case management
- Outreach and encouragement to become engaged in healthy lifestyle and related health-directed behaviors
- Comprehensive assessments
- Stratification of risk factors
- Targeted interventions
- Education
- Links to appropriate community resources
- Disease specific outreach/activities
- Tracking of outcomes

The goals of Missouri Care‗s Case Management Program are to:
- Ensure that a member receives needed care without interruption
- Identify barriers to care and help coordinate services and interventions that will have a positive impact on the member‗s condition and promote improved health outcomes
- Increase the number of members using medications correctly, in both frequency and dosing
- Reduce longer-term premature morbidity (complications) and mortality of disease(s)
- Decrease the incidence of ER and inpatient visits, when care could be supplied either to prevent such visits, or in place of such visits
- Teach prevention/wellness and better overall management of disease states, resulting in healthier lifestyle choices
- Enlist family, caregiver or other support entities to aid in maintenance of wellness activities
- Track outcomes to identify opportunities to improve the program

• Assure, where possible:
  ○ Appropriate use of preventive measures
  ○ Better methods of adherence, aimed at resulting in better perceived quality of life

Missouri Care makes case management services available to all enrolled members or populations who are identified as having health problems or situations that may benefit from case management, as identified by predictive modeling, health plan staff and referrals. Referrals to case management may originate with a member's primary care, attending, or treating health care professionals or providers; a family member or caregiver; health plan staff members in other departments (such as Precertification, Concurrent Review, Member Service, Quality Management); the Senior Medical Director or with a state agency. Members may also self refer.

Educational information promoting a healthy lifestyle is available to all case management members through a variety of resources such as the Missouri Care Web site, newsletters, booklets and specific educational mailings.

During this reporting period Missouri Care enrolled the following contractually required populations in case management: 94 Children with Elevated Lead Levels, 546 Children with Special Needs and 989 Perinatal cases.

Disease Management
Missouri Care provides disease management programs to assist health care providers in managing members diagnosed with targeted chronic illnesses. Illnesses included in disease management initiatives are asthma, diabetes, COPD, and CHF. They frequently result in exacerbations and hospitalizations (highrisk), require high usage of certain resources and have been shown to respond to coordinated management strategies. Disease management programs are structured around nationally recognized, evidence-based guidelines. They include interventions designed to address a member's level of risk, and reporting methods and formats to measure and monitor outcomes.

The Disease Management Program includes member and provider outreach. Interventions include an introduction letter and telephone call to the member. A letter is also sent to the member's PCP explaining the Disease Management Program. A risk assessment is administered to determine severity, medication use and management techniques. Education mailings include education materials on medications. Providers are notified of members' enrollment in the program.

Mental Health Care management including Care Management
Behavioral Care Management
Missouri Care's behavioral health care manager is responsible for daily prior authorization and concurrent review operations. Duties include documenting and evaluating requests for inpatient and partial levels of care, as well as requests for outpatient services beyond the initial authorization. The function is available 24 hours a day, seven days a week, 365 days a year. Missouri Care maintains a toll-free telephone number for members, behavioral health professionals and organizational providers. Care management staff is responsible for determining the member's enrollment and coverage of the service, determining the behavioral health provider's network affiliation, identifying potential coordination of benefits issues, and determining whether the service and level of care requested are consistent with LOCUS/CALOCUS criteria. Care management staff may authorize services if the request is supported by the review criteria and may deny authorizations for administrative reasons. However, the Senior Medical Director must review any potential medical necessity denials. Only the Senior Medical Director may decide to deny authorization based on clinical criteria.

The care manager informs the inpatient provider of the members' recent health care service history including psychiatric inpatient admissions, emergency room visits for the prior year, psychiatric outpatient services for the prior six months, and medications for the prior 90 days. Missouri Care's behavioral health care manager assists the inpatient facility with discharge planning. Discharge planning begins at admission. The care manager begins efforts to arrange appropriate aftercare for the member when notified of an admission. When a member has an established outpatient provider the care manager arranges the aftercare with the existing provider. If there is no existing relationship the care manager arranges the aftercare based on need and availability. This practice has led to prompt aftercare following inpatient for our members. The care manager also works with the facility to ensure the member is prescribed medications on the preferred drug list or that prior authorization requirements are met for a non preferred medication.

Behavioral Case Management
Case management is an integral part of the Behavioral Health Department. Case management allows Missouri Care to coordinate care through a continuum of services. The goal of case management is to provide the best and most efficient clinical outcome for each case-managed member, as Missouri Care is concerned with over- and underutilization of services. Missouri Care is an integrated health plan. The behavioral health and physical health case managers' work together to manage our most complex members. Missouri Care makes case management services available to all members. The following list is an example of the types of members enrolled in behavioral health case management:
- All members who are inpatient for behavioral health
- Members who are non compliant with medications, outpatient care, etc
- Pregnant members with substance abuse issues
- Members who have 10 or more ED visits in the previous 12 months
- Members with substance abuse issues (prescribed or illegal)
- Members identified internally with behavioral health issues
- Members identified through Predictive Modeling

Members are referred to behavioral health case management through a variety of sources, including the treating providers; primary care provider; self referral; or health plan staff members.

Missouri Care's behavioral health case managers work with the identified member to coordinate services and achieve desired outcomes. Identifying barriers to treatment is essential. Members with behavioral health issues often have complex physical concerns as well as their behavioral health concerns.

Behavioral health case managers work closely with medical case managers to co-manage the members' needs. In this reporting period, Missouri Care Behavioral Health implemented CaseTrakker, an integrated case management database. At this time the medical and behavioral health case managers are working out of the same database and have the ability to view all assessments, interventions, care plans and documentation.

Clinical Practice Guidelines
Missouri Care makes disease management practice guidelines available to health care professionals and encourages their use to improve the utilization of medications and treatments proven to be effective in treating certain conditions.

The disease management practice guidelines used by Missouri Care represent best practices and are based on national standards, reasonable medical evidence and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the Senior Medical Director, applicable medical committees, network physicians and, if necessary, external consultants. Disease management practice guidelines are reviewed at least every two years, or as often as new information is available.

Disease management guidelines are made available to practitioners in the Provider Manual. Articles in the quarterly provider newsletter inform network providers when new guidelines and updates are available. Practitioners may request copies of guidelines at any time by contacting their provider representative or the Missouri Care office of the CMO.

Credentialing and Re-credentialing

The credentialing and re-credentialing processes confirm the qualifications of health care professionals prior to their participation in, as well as on an ongoing basis once they become part of the Missouri Care provider network.

The objectives of the credentialing process are to:
- Maintain a fair credentialing process
- Obtain application information about a prospective participating health care professional's practice and background
- Verify applicable credentials with primary sources
- Obtain information from applicable sources about malpractice, sanction activity and felony convictions
- Complete verification of time-sensitive components within specified time frames
- Maintain the confidentiality and security of credentials files
- Include the chief medical officer and appropriate medical committees and oversight bodies in the credentialing process
- Meet the credentialing standards and requirements of applicable state and federal regulators and accreditation agencies

In SFY 08, Missouri Care approved 339 new providers and re-credentialed 158 providers through the Credentialing and Medical Quality Management Committees. Missouri Care performed audits of its seven delegated credentialing organizations:
- University of Missouri, Columbia
- Capital Region Medical Center, Jefferson City
- Children's Mercy Hospital, Kansas City
- Burrell Behavioral Health, Springfield
- Pathways/Midwest Behavioral Healthcare Mgmt, Inc, Clinton
- Crown Optical, Alton, IL
- Bridgeport Dental

These seven organizations credential approximately 1,000 providers.

Medical Record Review

Missouri Care conducts medical record reviews as part of its annual HEDIS hybrid record review process and during the investigation of member quality issues. During the spring of 2008, Missouri Care reviewed more than 1000 records. The following trends were noted: providers are missing opportunities to provide well child services during routine visits; prenatal and postpartum services were provided but not billed, and some postpartum visits were scheduled outside of required timeframe. When problems are identified, providers are educated on an individual level and trends and areas for improvement are highlighted in Missouri Care's quarterly provider newsletter.

Subcontractor Monitoring
Missouri Care has delegated to designated subcontractors the responsibility for provision of pharmaceutical, dental, vision and medical transportation services to Missouri Care members. These activities meet the policies, procedures and contractual requirements of Missouri Care. These designated subcontractors shall fulfill their own quality assessment and improvement processes to ensure that Missouri Care members receive safe, quality services. They must also work with Missouri Care to provide member service satisfaction through continuous quality improvement. Missouri Care retains the oversight function for quality management. Although Missouri Care delegates the authority to perform the function, it does not delegate the responsibility for assuring the function is performed appropriately.

Missouri Care performs annual audits of its subcontractors, holds oversight meetings throughout the year, and submits a separate Subcontractor Oversight Annual Evaluation Report. Oversight outcomes and findings are noted in the following areas: 1) access/availability, 2) fraud and abuse, 3) grievances and appeals, 4) performance projects and measures, 5) encounter data, 6) prior authorization denials, and 7) timely payment.

In SFY 08 Missouri care monitored the following four subcontractors:
- Express Scripts, Inc.
- Crown Optical
- Bridgeport Dental
- Medical Transportation Management

Express Scripts, Inc. (ESI)
ESI continues to work on decreasing the price for single-source brand prescriptions.

Crown Optical
Crown Optical continues the expansion of the vision network for Missouri Care. They have recruited providers in the central Missouri area. In addition, they have upgraded their system to provide automated reports of member complaints as well as prior authorizations/denials. Crown did report having problems receiving claims from outside providers due to a problem with software updates, but were working to resolve the issue.

Missouri Care monitors encounters submitted from Crown Optical for completeness, accuracy, and timeliness. No additional issues were identified during the reporting period.

Bridgeport Dental (BDS)
BDS submitted encounters in a timely manner. Provider demographic data accurately shows all dental providers that are used by Missouri Care members. Missouri Care members may visit providers outside of the MO HealthNet Central region. The Missouri Care network currently includes all providers. Ongoing updates are conducted on a monthly basis to compare additional providers and associated denied encounters.

Dental penetration rates remained low. Missouri Care began partnership with a new dental provider, Doral Dental, in September 08.

Medical Transportation Management (MTM)
MTM submitted encounters in a timely manner. MTM continues to have issues with member _no shows'. MTM also implemented a new procedure of reporting all provider no shows as grievances. Additionally, a new process was implemented by MTM to ensure that non-eligible members were not being included in the transportation benefit.

Molina Healthcare of Missouri

Provider Satisfaction
After the reporting period, MHMO contracted with The Meyers Group to conduct a provider satisfaction survey of 1000 providers within its network across all 3 regions (Eastern, Central, and Western) in an effort to receive feedback about their satisfaction with MHMO. A follow-up phone call with providers was instituted in an effort to complete the survey if a survey was not received through the mail. It is essential to obtain feedback from MHMO's providers in order to deliver quality service to its members. The focal point of the survey covers satisfaction in the following areas;
- Customer Service/Provider Relations
- Quality of Molina Healthcare of Missouri's Network
- Coordination of care
- Utilization Management
- Quality Improvement
- Claims and Finance Issues
- Pharmacy and Formulary
- Overall Satisfaction

The results from this survey are ongoing.

MHMO has developed a process to provide clear concise direction in addressing the types of issues related to provider complaints, appeals, claims processing, contracting, credentialing, member services and outreach. This process will be utilized by the Managers of CG & A, Provider Services, Provider Relations, Claims, Contracting, Medical Management, Credentialing, Member Services and Outreach. The Manager will determine the nature of the issue within their department and the process in achieving a resolution. The MPSC committee reviews provider issues and gives final approval of the resolution.

Care Coordination
Effective coordination for special needs members has two main impacts. First and foremost, it promotes more effective, coordinated care for these individuals and better support to their families and caregivers; both of which optimize the chances for positive outcomes. Second, a goal of active case management is to make care more cost effective, so limited MO HealthNet funds can be spread among more eligible Missouri residents.

Case Management
MHMO's concept of case management is a more intensive support or outreach to members with a variety of clinical conditions and/or social circumstances that, if left to self-management, may reduce the possibility of a positive outcome. Identification of participants for enrollment in case management comes from multiple sources. Case managers review the State's Children with Special Health Care Needs list to identify children who might benefit from case management. Referrals come from the preauthorization nurses and from the nurses performing chart review during the concurrent review process. Pharmacy and claims data are also a source of potential candidates. The PCP, specialist, or social worker may also refer members. The participant,

parent or guardian themselves may request assistance from the case management nurses. Also when a new member is enrolled in MHMO, a Welcome Call is initiated. During this call, the member services representative may obtain information that would prompt a referral to case management.

When a referral is received, all information pertaining to the member is reviewed to determine whether the member may be a candidate for case management services. If the case manager determines that additional information is needed, the nurse may contact the provider or member (parent/guardian) to assess the member's needs. Based on the information received, a participant may be enrolled into case management and assigned a case manager.

MHMO assigns case managers based on the level of expertise necessary to effectively support the condition and/or social circumstance being managed. The case manager is responsible for, but not limited to, communicating across the health care team continuum; negotiating with providers when appropriate; facilitating, coordinating and documenting individualized treatment plans, health care service(s) and/or community service resources.

The case managers work under the direction of and collaborate with the Department Manager and the Director of Medical Management. The Chief Medical Officer is directly involved with the management of participants enrolled in case management. The Medical Director's clinical team meets weekly and as needed to evaluate the participants' needs, identify areas of opportunity and redesign and update interventions and goals as needed.

MHMO has policies specific to the types of cases managed under the Case Management program for conditions such as but not limited to high risk OB, lead and special needs. The case management policies refer to the severity of the clinical condition, community practice guidelines, benefits, and community service resources that promote the best outcome for the member. The Case Manager works collaboratively with the PCP, specialists and ancillary service providers to promote optimum outcomes for members.

Disease Management Program
MHMO incorporated disease management into case management. See the case management information above.

Mental Health Care Management including Case Management
MHMO encourages its' mental health subcontractor to coordinate treatment services with the members' PCP.

Clinical Practice Guidelines
MHMO uses clinical guidelines to evaluate the medical necessity of requested services and promote access to the most appropriate services at the most cost effective setting based on solid current clinical practices. Use of nationally based criteria promotes the consistent application of available benefits based on the individual circumstances and/or condition of the member. Examples of these are: Inter-Qual Criteria for Long-Term Acute Care, Sub acute and Skilled Nursing, Rehabilitation and Home Care, ACOG for Obstetrical Needs, KCQIC Guidelines for Management of Essential Hypertension and KCQIC Guidelines for Tobacco Control, Missouri

Consensus Diabetes Management Guidelines for Adults, NHLBI Guidelines for the Diagnosis and Treatment of Asthma.

Credentialing and Re-Credentialing
MHMO maintains a credentialing program that identifies criteria for participation of licensed health practitioners, and the processes involved in selection, retention and termination of participating practitioners. MHMO's selection and evaluation process assures that providers available to serve MHMO members are qualified to perform the services members require and can work well within the delivery system that has been developed. MHMO's PRC serves as the approving body of providers to the network.

MHMO contracted with a CVO to perform primary source verification of credentialing applications through March 2008. As part of the integration with Molina Healthcare, Inc., primary source verification of credentialing applications is now performed internally through Molina's Corporate Credentialing department. Cactus software is used to manage credentialing and recredentialing information. MHMO delegates credentialing to some of its subcontractors and larger provider groups. The DOC and PRC provide oversight of the delegated function.

Medical Records and Site Review
MHMO requires medical records to be maintained in a manner that is current, detailed, organized and permits effective, confidential patient care and quality review. MHMO has a process to assess and improve, as needed, the quality of medical record keeping.

At the time of re-credentialing, MHMO conducts a medical record review of PCP's as indicated by the NCQA standards. Credentialing guidelines adopted by MHMO have been reviewed and approved by the PRC. The PRC considers medical record review reports with other criteria and information about the practitioner when making recredentialing determinations. A medical record review is conducted unless the location has fewer than 50 MHMO members assigned. Once the PCP medical group has achieved compliance with the medial record review, they do not need to be routinely reviewed until they are re-credentialed in 3 years.

MHMO's policy is to ensure that the offices of all Primary Care Practitioners (PCP), OB/Gyns and all other high volume care practitioners meet MHMO's site review standards when a threshold of three (3) or more grievances have been filed by MHMO members. This policy is compliant with the NCQA standards. After consideration of the severity of grievance and a ―reasonable complaint" has been established, a site review will be conducted within 60 days of determining the threshold has been met as outlined by NCQA standards. Molina assesses the quality, safety and accessibility of the office site where care is delivered to the MHMO members.

Subcontractor Monitoring
MHMO subcontracts for the following services: pharmacy, mental health management, routine vision care, dental management, and transportation management
- Express Scripts, Inc. manages MHMO's pharmacy benefit. Express Scripts is MHMO's primary provider of PBM services, specialty injectables, and formulary and rebate management. In the next reporting period, Express Scripts will be replaced by RxAmerica.

- St. John's Mercy Managed Behavioral Health provided mental and behavioral health and substance abuse services through network providers including psychiatrists, psychologists, social workers or other mental health counselors. They provided services from July 1, 2007 to October 31, 2007. On November 1, 2007, MHNet began to provide these services. MHNet is NCQA accredited.
- Bridgeport Dental provides covered comprehensive dental services, including diagnostic, preventive, ancillary, restorative, endodontic, prosthodontic, and orthodontic services, and oral surgery.
- Medical Transportation Management manages a network furnishing non-emergency medical transportation services for eligible members.
- Vision Services Plan provides routine vision and eye care services for eligible members under the age of 21 and limited routine vision benefits for members 21 and over. During the next reporting period, these services will be provided by March Vision Care.

The subcontractors are required to adhere to the requirements contained in the State contract with MHMO. Oversight meetings with each subcontractor are held quarterly. Any noted deficiencies are addressed with the subcontractor through an action plan that details time frames and objectives. Information from the quarterly meetings is reviewed by the DOC.

Rights and Responsibilities

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Provider Complaint, Grievance and Appeal Management
Provider Complaints, Grievances and Appeals are processed in an organized and timely manner in accordance with the Provider Complaints, Grievances, and Appeals and Member Grievance & Appeal Corporate Policies and Procedures. The Polices and Procedures are consistent with the requirements of the Federal Government, State Government, and other regulatory entities. The BA+ Board of Directors reviews and approves this policy annually.

BA+ continues to track and trend Provider Complaints, Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. The results are presented to the BA+ Oversight Committee.

Provider Complaints, Grievances, and Appeals
    a. During FY2008, there were 437 provider complaints.
    b. During FY2008, there were 19 provider grievances.
    c. During FY2008, there were three provider appeals.

Member Grievance and Appeal Management
Member Grievances and Appeals are processed in accordance with the Provider Complaints, Grievances, and Appeals and Member Grievance & Appeal Corporate Policies and Procedures. The Polices and Procedures are consistent with the requirements of the Federal Government, State Government, and other regulatory entities. The BA+ Board of Directors reviews and approves this policy annually.

BA+ continues to track and trend Member Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. The results are presented to the BA+ Oversight Committee.

Member Grievances and Appeals
    a. During FY2008, there were 118 member grievances.
    b. During FY2008, there were 162 member appeals.

PERFORMANCE MEASURES/ANALYSIS
Performance measures used to track Provider Complaints, Grievances, and Appeals and Member Grievances and Appeals are:

a. The timeframe for resolution of member grievances is 30 calendar days. The timeframe for resolution of member appeals is 45 calendar days.

        1. Goal is 95% compliance

2. In FY2008, member grievances were 73% compliant and member appeals were 81% compliant.

b. The timeframe for resolution of provider complaints is 10 calendar days. The timeframe for resolution of provider grievances is 30 calendar days. The timeframe for resolution of provider appeals is 60 calendar days.

1. Goal is 95% compliance for all categories (provider complaints, grievances and appeals).

2. In FY2008, provider complaints were 90% compliant, provider grievances were 85% compliant, and provider appeals were 100% compliant.

Confidentiality
Protection of confidential information has always been of the highest priority at BCBSKC. BCBSKC educates employees and requires each employee sign a confidentiality agreement at the time of employment and annually. The agreement states that employees have read and accept accountability for adhering to the Standards set forth in the Code of Business Conduct and Corporate Policy and Procedures regarding conflicts of interest and confidentiality, including Corporate Policy and Procedure I-4 Conflict of Interest, Corporate Policy and Procedure I-19 Privacy of Member Information, Corporate Policy and Procedure I-20 Confidentiality of Business Information (non-PHI), and related policies, and understand and agree that any violation of these Standards can lead to disciplinary action up to and including termination for cause where appropriate. Copies of the signed documents and monitoring for compliance are retained in the Human Relations Department.

Another part of confidentiality is making sure the information that is retained or transmitted is protected and secure. In 2005, BCBSKC implemented provisions of the HIPAA Security Rule.

BCBSKC continues to maintain compliancy with these rules through our Corporate Privacy and Security Office functions including among other efforts, training on HIPAA accountabilities, monitoring of privacy and security practices, reviewing and updating existing procedures and responding to member's rights for requests and authorizations.

Children's Mercy Family Health Partners

Provider Complaint, Grievance and Appeal Management
Children's Mercy Family Health Partners (CMFHP) recognizes the importance to providers of having available effective complaint, grievance and appeal mechanisms in the event that they do not agree with a health plan decision. CMFHP offers these mechanisms to address, for example, potential disagreements regarding medical necessity, denials of services, changes in services, and claim payments.

Since 1997, CMFHP has coordinated the program's evolving complaint, grievance and appeal service delivery requirements similar to those described in the Request for Proposal. CMFHP uses analysis of complaints, grievances and appeals as a mechanism to identify areas for improvement. Complaints, grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce complaints, grievances and appeals related to the issue in question.

Since 2000, CMFHP has tracked and trended complaints, grievances and appeals received. Children's Mercy Family Health Partners did not implement any new initiatives during the current reporting year, but monitored the one issue and initiative from the previous reporting period.

The previous issue that emerged as significant and high volume in the reporting period July 1, 2006 through June 30, 2007: Claims Administrative Denials for cosmetic claims related to treatment of viral warts and minor skin lesions. To address these findings and assess the number of appeals received relating to cosmetic denial appeals, CMFHP identified the following issues:

- Claims denials for cosmetic services, a non-covered benefit, generated two hundred-sixty (260) provider complaints, grievances and appeals about the treatment of viral warts and minor skin lesions. One hundred ninety-six (196) complaints, grievances and appeals were overturned with additional information. This trending of the Provider complaints, grievances and appeals resulted in an internal review of both the medical issue as well as the processing of these types of claims.

To address these findings, CMFHP implemented the following:

- Health Services Review Committee reviewed diagnosis and procedure codes, recommended changes to the adjudication process to pay for services and treatment of viral warts and minor skin lesions. Claims implemented the change to the adjudication process in second quarter 2007. Implementation of this process change has decreased provider appeals.

After one year, CMFHP has the following improvement:

- Claims denials for cosmetic services that resulted in a Provider complaint, grievance and appeal during the current reporting period have decreased 74% compared to the previous reporting period.

Children's Mercy Family Health Partners continues to monitor the effectiveness of complaint, grievance and appeal activities and works to identify additional initiatives that will result in process improvement.

Member Grievance and Appeal Management
Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available effective grievance and appeal mechanisms in the event that they do not agree with a health plan decision rendered on their behalf. CMFHP offers these mechanisms to

address, for example, potential disagreements regarding medical necessity, denial of services, change in services and claim payments.

Since 1997, Children's Mercy Family Health Partners has coordinated the program's evolving grievance and appeal service delivery requirements similar to those described in the Request for Proposal.

CMFHP uses analysis of grievances and appeals as a mechanism to identify areas for improvement. Grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce grievances and appeals.

Since 2000, CMFHP has tracked and trended grievances and appeals received. In the reporting period July 1, 2007 through June 30, 2008, two issues emerged as high volume: member grievances for transportation and appeals for speech therapy services. To address these findings and decrease the number of grievances and appeals received relating to transportation and speech therapy, Children's Mercy Family Health Partners identified the following interventions:

- Tracking and trending of member grievances regarding transportation: Resulted in a total of 243 transportation grievances.

- CMFHP identified ten (10) member appeals for denied services for speech therapy; three (3) appeals were overturned with additional information.

Since the implementation of these grievance and appeal activities and initiatives, CMFHP has been able to improve various health plan services to the benefit of all members.

- The transportation member grievances were reporting to Transportation Subcontractor Quarterly meetings resulted in a subcontractor change in 2007. Ongoing tracking and trending of transportation grievances resulted in a health-plan performance improvement project. The current transportation provider has provided increased coordination and responsiveness. First quarter analyses from the non-clinical performance improvement project demonstrated an increase in utilization of transportation services per thousand members and a nine percent (9%) decrease in overall transportation related member grievances per thousand members from 2006 to first quarter 2008.

- Tracking and trending of member appeals: identified twenty-three percent (23.8%) of appeals were related to denied services for speech therapy. This trend in conjunction with the biannual inter-rater reliability audits and the review of medical necessity data from 2006 and 2007 identified no inconsistencies in decision outcomes.

Children's Mercy Family Health Partners continues to monitor the effectiveness of grievance and appeal activities and works to identify additional initiatives that will result in improvement.

Confidentiality
At the time of employment, Children's Mercy Family Health Partners employees are required to sign a Confidentiality Agreement. These agreements are maintained in the employee's Human

Resource file. The Confidentiality Agreement, in conjunction with the Code of Conduct, provides the employee with guidelines which represent the corporation's commitment to ethical behavior and actions, including the employee's responsibility to ensure confidentiality of member, provider and plan information.

Children's Mercy Family Health Partners successfully implemented HIPAA prior to April 14, 2003. All employees attended the initial mandatory HIPAA privacy and security training and are required to attend or complete the annual training online. Each employee also received education and training on privacy and security of data during their new employee orientation.

The Compliance Officer provides articles for the employee newsletter, In the Know, on a regular basis regarding privacy and security related issues. In addition, employees have access to the Hospital's Compliance department newsletter on the Hospital Intranet which hosts additional resources and information regarding privacy and security.

<div align="center">

Harmony Health Plan of Missouri

</div>

Provider Complaints
The Plan operates a provider services function in which providers can ask questions, file inquiries and complaints, and get problems resolved. The Company's customer and provider services function is staffed to receive telephone calls and meet personally with providers. The Plan identifies the person(s) designated to receive and process complaints, grievances, and appeals. This person collects all pertinent facts from all parties during the investigation. All inquiries are logged in the call tracking system. The Plan probes the inquiries so as to validate the possibility of any inquiry actually being a complaint. The Plan identifies and tracks inquiry patterns.

This process is handled by the Customer Service and Provider Services Department.

Complaint Process
Complaints can be filed verbally or in writing within one year of the incident that resulted in a Complaint. Complaints are resolved within ten (10) calendar days of their filing. The provider(s) and the Plan attempt to resolve all Complaints before proceeding to a Grievance.

At the time of the Company's decision regarding a complaint, a notice is sent to the provider advising of their right to file a grievance. Requests regarding provider administrative complaints or Provider Medical Necessity Complaints are handled in the Appeals Department. All other Complaints are processed by the Customer Resolution and Provider Services Department.

Member and Provider Grievances
Provider Grievance Process
The Plan provides a Grievance Process which providers can use to file their dissatisfaction with the Complaint resolution. If a provider is dissatisfied with the Complaint resolution, the provider can file a Grievance in writing with the Plan within ninety (90) calendar days of the Complaint resolution. The provider must deliver a written, substantiated agreement with the Complaint

resolution to the Company. The Plan then acknowledges the receipt of Grievances in writing within ten (10) business days after receiving a Grievance. Grievances are investigated by the Plan and reviewed by the designated authority within the Company. The Plan reaches a decision on each Grievances within thirty (30) calendar days of the filing date. At the time of the company's decision regarding a Grievance, the Plan notifies the provider in writing of their right to file an Appeal.

Requests regarding provider Administrative Grievances or provider Medical Necessity Grievances are handled in the Appeals Department. All other Grievances are processed by the Customer Resolution and Provider Services Department.

Member Grievance Process
The Company refers all members, member's representative, and providers who are dissatisfied with the Company or its providers to the Appeal & Grievance Coordinator. Appeals are directed to the Appeal Coordinator in the Appeals and Grievance department. Grievances not concerning an alleged quality of care issue are handled by the Customer Service Grievance Coordinator (CSGC).

The Director of Appeals and Grievances, to ensure appropriate processing in accordance with State regulations, monitors all grievance cases handled by the CSGC. The Grievance Coordinator within the Appeals and Grievance Department handles grievances concerning a quality of care issue. These cases are also reviewed by a Clinical Coordinator and referred to the Medical Director, if after reviewing medical records a potential quality of care issue is identified.

Procedural steps are clearly specified in the member handbook for members and the provider manual for providers, including the address, telephone number, and office hours of the Coordinator. The Member Handbook and Provider Manual includes:

Member rights to MO HealthNet Fair Hearing, the method for obtaining a hearing, the rules that govern representation at the hearing, and the address for pursuing a fair hearing.

- Member rights to file grievances and appeals and requirements and time frames for filing.
- The availability of assistance in the filing process.
- The toll-free numbers to file oral grievances and appeals.
- Member rights to request continuation of benefits during an appeal or MO HealthNet Fair Hearing process and, if the Plan's action is upheld in a hearing, the fact that the enrollee may be liable for the cost of any continued benefits.
- Member's right to receive grievance policies and procedures verbally and in the member's primary language.

Organizational Structure
The Grievance team is proactively reviewing how they can better assist members through faster processing of Grievances and stronger controls to ensure compliance with all state and federal regulations and contracts.

Activities/Objectives
Project – Implement Grievance Quality Monitoring Tool

Objective/Purpose – To improve the quality of grievance case work and reduce repetitive errors.

Results – We are able to give "real time" coaching and feedback to the grievance coordinator. Implement new timing/correction and new procedures.

Analysis – The criteria of the monitoring tool has evolved, by allowing the leadership team to add criteria as trends were identified.

Barriers/Root Cause – Obtaining the appropriate resources to support the auditing of case file to confirm process and procedures are followed.

Improvements – To increase sample size: we have double the workload for review for each coordinator from 5 cases to 10.

Project - Grievance Database
Objective/Purpose – To implement a grievance database to capture and quantify all grievance cases.

Results – Enhance reporting to capture common grievance types and the markets in which they are related.

Analysis – Has enabled reporting that captures top five grievance issues, turn around time for CSQIW, MAC and QIC work groups.

Barriers/Root Cause – Obtaining the appropriate time to support the development of the database.

Improvements – Improve reporting analysis and line of site to the status of case work in real time. Improve quality by automation, less time to close cases

Plans for 2009 – Further enhance the grievance database to integrate with Paradigm systems and automate member correspondence beginning with the acknowledgment letter. Enhance the grievance database to track misrouted and mishandling outcome of cases.

Member and Provider Appeals
Appeal: A request by a member, his/her representative (member appointed or the estate representative of a deceased beneficiary with appropriate documentation), or provider (acting on behalf of the member and with the member's written consent) to reconsider an "action" by the Company. The Appeal procedure must be the same for all Enrollees.

Expedited Appeal: An appeal for a service that has not already been rendered. Process followed when the Plan determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

The member, member's representative, or provider may file an expedited appeal either orally or in writing. For oral filings, time frames for resolution begin on the date the plan receives the oral filing.

Disputes are reviewed according to eligibility and benefit guidelines, timeliness of requests, and McKesson/ InterQual Level of Care guidelines. Inquiries and Appeals are processed by Appeals Coordinators and- when appropriate, clinically reviewed by physicians who were not involved in the initial denial. All appeal determinations are made by a Medical Director, with the advice and consent of the Appeals Committee.

Expedited appeals are immediately entered in the computer system and the time received is documented. The Health Plan shall resolve each expedited Appeal and provide notice to the Enrollee, as quickly as the Enrollee's health condition requires, within State established time frames not to exceed seventy-two (72) hours after the Health Plan receives the Appeal request, whether the Appeal was made orally or in writing. The Health Plan will provide written notice of the resolution, as required by MO HealthNet contract.

It is the policy of the Company and the Appeals department to audit appeal files. Department audits are conducted monthly on provider and member files.

Organizational Structure
The Health Plan's Appeals Committee monitors appeal trends, and appeals overturn rates as part of the ongoing monitoring activities. All appeals activities are reported to the Medical Advisory and Quality Improvement Committees. If a trend is identified of overturned denials relating to medical necessity or benefit coverage, an in-depth review of the utilization decision process will be undertaken with the implementation of an intervention plan, as appropriate.

Between July 01, 2007 and June 30, 2008, the Appeals Committee (AC) met fifty two (52) times. The Committee membership was comprised of the following: Medical Directors for all regions; Appeals staff; and Representatives from Legal or Compliance all of whom have been unaffiliated with the case prior to the review.

Activities/Objectives
- Improving Operating Efficiencies initiative was put into place to continue to improve staff productivity in the processing of appeals.
- Enhanced policies and procedures to reflect appropriate language and implemented accordingly
- Cross-trained staff on other processes within the department to provide better coverage at times of decreased staffing due to vacations and sick days.
- Instituted the sending of acknowledgement and closure letters
- Improved operating metrics

- Increased the amount of automated letters

Outcomes
New databases, changes in policies and procedures and additions to FTE counts have played significant roles in improving Appeal processes.

During annual reporting timeframe: there were 4 member appeals all were overturned. There were 105 provider complaints, 3 provider grievances and 1 provider appeal, those that were upheld (47) were due to no prior authorization, no medical necessity, or lack of medical information. The remaining appeals were all overturned.

Opportunities
- The Appeals Committee will continue the review of member and provider medical necessity appeals and the review of administrative and benefit appeals.
- Continue managing workflow productivity improvements as a result of enhancements to systems and operational processes.
- Continue focus on initiatives with Customer Service to evaluate trends related to provider complaints, PCP changes.
- Continue joint project with Claims to conduct root cause analysis of No Prior Authorization Denials.
- Overturn rates will be further explored in 2008 comparing internal and external reviews. These results will be tracked and trended. Any issues that arise from this analysis will be targeted for root cause analysis with corrective action as needed.
- The external review process will be analyzed to determine which specialties are most frequently used. A discussion regarding the findings will be brought to the group.
- Continued upgrades to Appeals and Grievance Database
- Implementation of new technology for scanning and workflow solutions
- Review appeals issues in appropriate committees accordingly

There will be a Root-cause analysis to further reduce submissions of cases in reference to the following:
- Failure to obtain prior authorization
- Potential quality of care complaints

Confidentiality
In accordance with WellCare's code of ethics and HIPAA Compliance Program, WellCare will safeguard PHI and protect against the unauthorized access, use and disclosure of PHI. In addition to the *Trust* Program detailed below, WellCare has extensively documented the policies and procedures which address all aspects of protecting and safeguarding member PHI. To date, there have been no instances of a PHI breach within the Harmony Health Plan of Missouri membership population.

WellCare's corporate ethics and compliance program, entitled the *Trust* Program, consists of five structural components: a) the written elements of the *Trust* Program, b) the Vision, Mission and Core Values, c) the Standards of Conduct, d) the Compliance Organization and e) the Policies and Procedures underlying the *Trust* Program.

The *Trust* Program does not attempt to restate all of WellCare's existing Policies and Procedures regarding ethical and legal compliance and is not intended to replace any of our Policies and Procedures. Rather, the *Trust* Program is intended to unify and build upon those Policies and Procedures, all of which remain in place and are a vital component of the *Trust* Program.

Scope of the *Trust* Program

The *Trust* Program applies to the WellCare Group of Companies, its Board of Directors ("Directors"), associates, and, as applicable, its business partners. Any new companies that WellCare may acquire or establish from time to time will also become subject to the *Trust* Program. Additionally, WellCare encourages, and in some cases requires, its business partners, including independent contractors, to follow the *Trust* Program's values. WellCare considers our business partners to include, among others, our delegated service vendors (e.g., entities that take risk from WellCare), service vendors (e.g., entities that provide basic services to WellCare), delegated entities (e.g., clinical labs and durable medical equipment companies), WellCare's regulatory stewards and WellCare's contracted providers (e.g., physicians and hospitals). WellCare believes that our members ("Members") will also benefit from the *Trust* Program because they deserve to have their vital health care needs served by a company with high standards of business ethics.

Purpose of the *Trust* Program

The *Trust* Program is designed to assist WellCare to conduct its business in accordance with applicable federal and state laws and WellCare's high standards of business ethics. Additionally, the *Trust* Program is intended to satisfy the requirements of the Federal Sentencing Guidelines, the Department of Health and Human Services, the regulations of the Office of the Inspector General, the regulations of the various regulatory agencies in each of the states we serve, the Securities and Exchange Commission and the New York Stock Exchange. The *Trust* Program provides a framework for action within WellCare and is a prerequisite to achieving our business goals.

As part of the *Trust* Program, WellCare has created and will continue to create a more detailed set of Policies and Procedures specifically relating to our Medicare plans, MO HealthNet plans and all other product lines.

Compliance Organization

The Board of Directors of WellCare Health Plans, Inc. has adopted the *Trust* Program, and has required that each operating company within the WellCare Group of Companies adopt the *Trust* Program. The Board of Directors of WellCare Health Plans, Inc. oversees the activities of the Boards of Directors of WellCare's regional operating companies through such means as it deems appropriate. Members of senior management are responsible for ensuring that WellCare, its Directors, associates and, in some cases, its business partners comply with the *Trust* Program, applicable federal and state laws and WellCare's high standards of business ethics. WellCare's Directors have designated the Chief Compliance Officer, with the assistance of a Corporate Compliance Committee, to have the authority to implement the *Trust* Program. The Chief Compliance Officer is responsible for coordinating the efforts of all associates involved in the *Trust* Program. Additionally, WellCare's Directors created the Corporate Compliance

Committee consisting of certain senior Area Leaders, the Chief Executive Officer, the Chief Compliance Officer, the General Counsel and such others as may from time to time be necessary as determined by the Chief Compliance Officer.

WellCare has a Corporate Compliance Department within the Legal Services Area which reports to the Chief Compliance Officer and assists the Corporate Compliance Committee in implementing and monitoring the *Trust* Program. The Corporate Compliance Department is supported by a Corporate Compliance Counsel who advises the Corporate Compliance Committee with respect to the *Trust* Program. Certain associates within the Legal Services Area, Area Leaders, department directors and managers and others, as needed, will be designated as "Compliance Coordinators" to assist in implementing and monitoring the *Trust* Program. In that capacity, the Compliance Coordinators will be responsible for ensuring compliance within their areas of operations and for reporting suspected violations of the *Trust* Program, applicable federal and state laws and WellCare's high standards of business ethics.

All Directors and associates of WellCare are participants in the *Trust* Program and may be required to certify in writing on an annual basis that he or she has conducted WellCare's business in compliance with the *Trust* Program.

Education and Monitoring Programs
WellCare will continue to maintain and update training and monitoring programs to educate its Directors and associates on the legal and regulatory requirements of their respective duties and positions, and to detect possible violations. These programs may consist of additional written policies, informational handouts and memoranda or, when appropriate, training seminars in selected areas. WellCare will continue to monitor and promote compliance with new federal and state laws and regulations.

Confidentiality of Medical Information
WellCare, its Directors, associates and business partners must protect the privacy of medical and health information received from and about Members and potential Members.

As part of its business, WellCare receives medical information and Protected Health Information from health care providers and Members, including information relating to individual Members' medical conditions and health status. WellCare will respect and preserve the privacy of this protected medical and health information as required by law. Except to the extent expressly permitted by the Member and by federal and state law, WellCare, its Directors, associates and business partners will not disclose such medical information and Protected Health Information to any third party. Furthermore, WellCare is required to preserve the confidentiality of protected medical and health information that remains in its possession. WellCare, its Directors, associates and business partners must access and disclose protected medical and health information only as necessary for the provision and coordination of health care services and as permitted by applicable federal and state laws in connection with ongoing operations.

All Harmony Health Plan members receive a copy of Harmony/WellCare's Notice of PHI with their Member Handbook mailing upon enrollment.

HealthCare USA

Provider Complaint, Grievance and Appeal Management
The data provided has been taken from Navigator, the HealthCare USA online system where provider and member issues are recorded. The information presented represents all three (3) regions (Eastern, Central and Western). Data from 2005 is not being used as a comparison. Data from 2005 was collected and analyzed using a different process, making the data not comparable to 2006, 2007, or 2008.

HealthCare USA established an interdepartmental, multi-disciplinary performance improvement team 2006 and revised the team participation in 2007 to review providers complaints, grievances and appeals, and member appeals and grievances and timeliness monthly. This group has the authority to initiate process and policy changes. The work group makes suggestions regarding additional training that may be needed by staff. Suggestions are made for educational information to be shared with providers through the provider newsletter.

Provider Complaints
   Non Medical
   - Increase in complaints at the start of 2008 due to expansion counties.
   - Large number of complaints in early 2008 due to non par pathology claims being denied for no authorization. A IT solution was identified so that these claims would now pay without needing an authorization.
   - Non medical complaints are generally claim related, with untimely filing being the number one complaint. These complaints are reviewed in an interdepartmental meeting to determine what processes can be changed in order to eliminate the need for the provider to file a complaint.
   Medical
   - Medical complaints have declined as we have identified contracts that are allowed a retro review. We now count these as inquiries rather than complaints. This gives us additional time to review the medical records and still allows the provider the three appeal levels.

Provider Medical Complaints per MM
Goal: 3.17 per MM

Source: Navigator

Provider Non-Medical Complaints per MM
Goal: 12.96 per MM
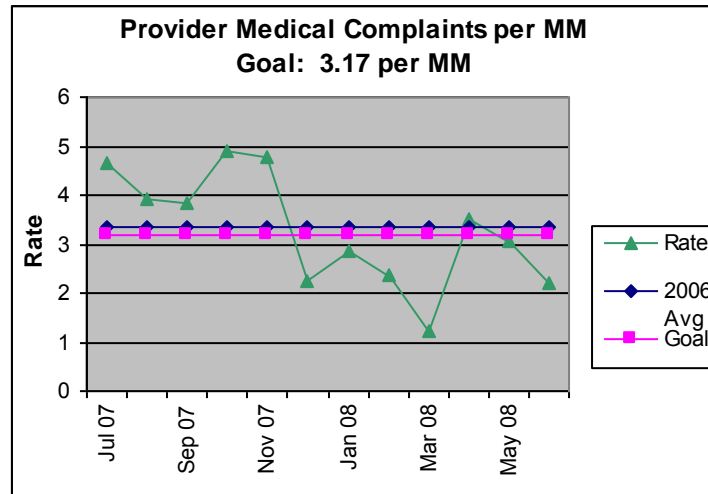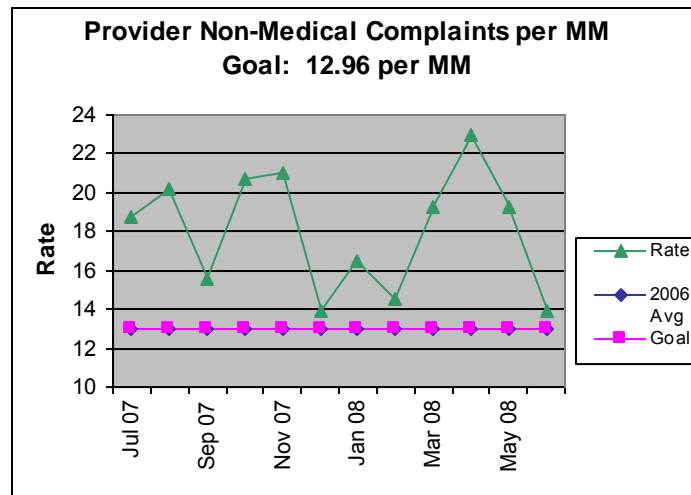
Source: Navigator

Provider Grievances

Non Medical
- Timely filing is one of the top grievances. At this level, the providers are giving information requested in the grievance which also effects overturns.

Medical
- Many of the grievances are from facilities that have hired outside firms to file their appeals. These firms continue to appeal denied days and observation rooms even though they do not meet Interqual criteria.
- Overturns for medical are lower than for the non medical grievances. Grievances are reviewed by like-specialty providers.

347

Provider Appeals

Non Medical
- Non medical third level appeals are low since most of the non medical appeals at any level are claim issues. Again, timely filing seems to be the one area where the providers continue to appeal.
- Overturns are determined by an appeal hearing made up of HealthCare USA management staff. Generally, the appeal is upheld. However, on occasion there may be an overturn. Since the number of third level appeals is small one overturn can make the overturn rate seem high in this area.

Medical
- Most third level medical appeals are done by the firms representing the facilities.
- At this level, the appeals are sent to two outside reviewers of like specialty to review the issue using Interqual criteria or other criteria determined by the situation.
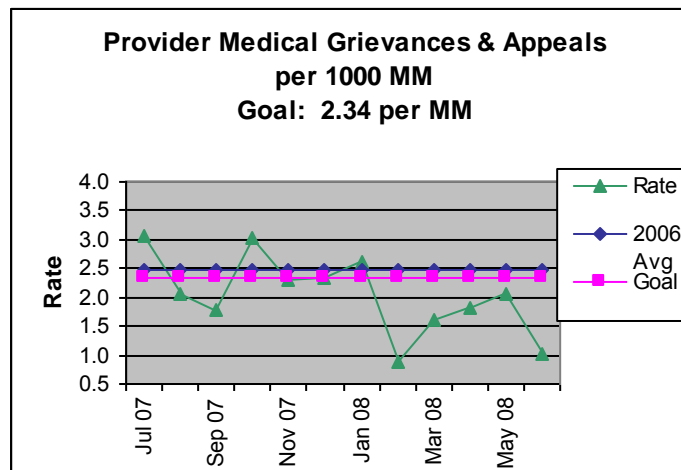
Source: Navigator
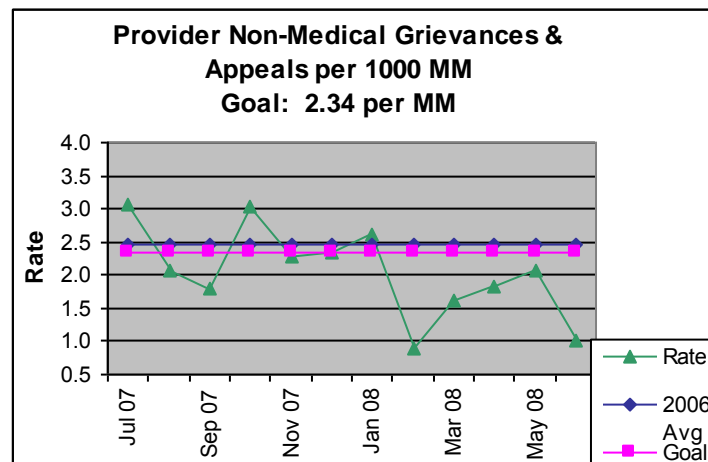
Source: Navigator

Member Grievance and Appeal Management
Member Appeals

- The number one member appeal is for orthodontic treatment. Members must meet a score of 28 or higher on the HLD or have an automatic qualifier outlined in the HLD.
- Member appeals are reviewed by two like-specialty providers. Overturns are usually as a result of receiving additional information on the case.
- Overturns for orthodontia have been due to reviews by a different dentist who may allow the braces when the score is close allowing that the molds could be off by enough to make the difference. We have been working with Doral in order to make the original decision the appropriate one.
- Denial letters for orthodontia were created to try to better explain the denial to the member. This has not lowered the number of appeals. 2008 appears to be running at the same rate as 2007.

Source: Navigator

Source: Navigator

349

Member Complaints – Transportation
- Not being picked up is the number one grievance from members. HealthCare USA works with MTM in order to improve the pick up of our members.
- Monthly a list of pregnant members is sent to MTM in order to assure that these members are given special attention for their transportation needs.
- Members with sickle cell disease have been flagged in MTM's system so that these patients receive special attention with their transportation needs.
- As individual needs are identified, MTM is notified and their system flagged so that special consideration can be given to these members.
- Education is given to members about calling the transportation vendor at least 5 days before their scheduled appointments.
- MTM's vendors are educated and disciplined when a trend is noticed.
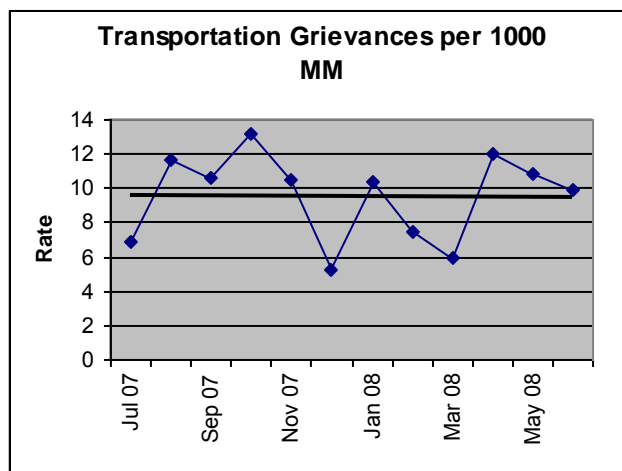
Source: Navigator

Member Complaints-Dental
- HealthCare USA has worked with Doral to ensure that there is an adequate network of dental providers.
- Issues that arise due to a dentist's behavior or his/her staff's behavior are addressed by Doral's provider relations department.
- Appointment availability can be problematic as many dentists have a wait for new patients. For emergency care HealthCare USA works with Doral so that the member can be seen sooner.

Member Complaints – Medical
- The main complaint in this category is the provider billing the member. This billing is coming from non par providers, out of state providers and ancillary providers. In

many of these cases the member has failed to provide the insurance information at the time of services. Bills are obtained and forwarded to claims for payment.

- Non par facilities out of state do not want to bill MO HealthNet providers as they have to accept our payment due to a federal guideline. Oftentimes they respond to this requirement by billing the member instead of the insurance company. In some cases the provider will submit the bill to the Plan. In cases where the provider refuses

Indicator	Mean 2006	Goal	2007 Mean	Goal Met
Member Grievances per 1000 member months	8.03	*	13.65	NA
Member Appeals per 1000 member months	2.14	2.03 (↓ 5%)	1.2	Yes 44% ↓
Overturn Rate	25%	15% or less	27.9%	No
Member % of timeliness	74.7%	100%	79.3%	No
Provider Medical Complaints per 1000 member months	3.34	3.17 (↓ 5%)	4.26	No
Provider Medical Grievances/Appeals per 1000 member months	0.69	0.65 (↓ 5%)	1.15	No
Overturn Rate	11%	15% or less	15.3%	Yes
Provider Non-Medical Complaints per 1000 member months	13.65	12.96 (↓ 5%)	17.6	No
Provider Non-Medical Grievances/Appeals per 1000 member months	2.47	2.34 (↓ 5%)	1.83	Yes 26% ↓
Overturn Rate	20.9%	20% or less	27.6%	No
Provider % timely 10 days – 1st level	63.6%	100%	40.6%	No
% timely 30 days 2nd level	89.2%	100%	82%	No
% timely 60 days 3rd level	94.1%	100%	74%	No

Source: Navigator

*2006 Data inaccurate and data capture corrected Jan 2007. The 2008 mean will be available in 2009.

to bill us, the member is asked to forward the bill to HealthCare USA.

	Classification	Interventions	Date
Member Issues	High Volume OB complaints about MTM transportation	Conduct a survey for high-risk OB members to determine cause of transportation grievances	Mar 07
		Send a list of all high-risk OB members to MTM to better facilitate coordination of care efforts and prevent transportation issues with this high risk population.	Feb 07; monthly
		Restrict OB transportation to van or car transport-no bus	Feb 07

		or metro-link transport.	
		Develop and distribute a magnet to all pregnant members with the phone number for MTM transportation service	Sep 07
		Meet monthly with MTM to address ways to improve member satisfaction and reduce grievances	Feb 07; monthly
	Asthma Member complaints about MTM transportation	Meet at least quarterly with MTM to address ways to improve member satisfaction and reduce grievances	Feb 07 and monthly
	Education regarding processes	CSO educated about dental benefits, specialist benefits, and locating providers	Jun 07
		Member services staff educated regarding querying members calling with a grievance about receiving bills from providers to clarify whether the bill is simply a statement , a request for additional information, or an actual bill	Jul 07
		Implementation of expanded Grievance Tracking Log to better identify trends	Feb 08
Staff Issues	Variation in overturn rates	Analyze and trend overturns of member appeals to identify any common patterns	Mar 07; monthly
		Implement record audit process to monitor entry and response timeliness	Jan 07; monthly
		Analyze and trend overturns of provider grievances/appeals	
		Analyze and trend first level complaints for patterns	
Provide r Issues	Authorization of Services Process	Auth requirement for inpatient E&M codes for medical admission eliminated	Oct 07
		HCA& Children's Mercy with automatic retro-review. First review is now treated as inquiry, allowing all three levels of appeal if denied on first review	May 07
		Auth requirement removed for non-par ambulance companies billing non-emergent services for hospital-hospital transfers	Aug 07
		System fixed to not deny ambulance claims with mental health diagnoses if benefits have mental health services carved out.	Aug 07
		PR to visit providers with high numbers of appeal for untimely filing to provide education	July 07
		Include article in provider newsletter educating providers about filing timeframes	July 07

		Auth Requirement for inpatient E&M codes for mental Health admission eliminated	May 08
		Auth requirements for MFM claims eliminated	Aug 08
Staff Issues	Education regarding processes	New staff hired and trained. In process of recruiting additional staff.	May 07
		Staff education on process for capturing all member grievances and provider complaints	Apr 07; ongoing
		New staff orientation to department specific policies/procedures	Mar 07
		Revision of current complaint, grievances, and appeals report to include specific data to identify trends	Apr 07; ongoing
		Compliance analysts educated regarding entering update status for authorizations and transcribing MD notes to improve timeliness of process	Sep 07; ongoing
		Instituted grand rounds and case management/disease management rounds with medical director and clinical staff	Aug 07; 4x/wk
		New medical director instituted Inter-rater reliability process for physicians reviewing appeals.	Sep 07
		Member services staff educated about dental benefits, specialist benefits, and locating providers	Jun 07
		Member services staff educated regarding querying members calling with a grievance regarding receiving bills from providers to clarify whether bill is simply notification that insurance co. was billed, a request for additional insurance info/clarification or an actual bill from the provider	Jul 07

Outcomes

Tracking of outcomes through June 2008:
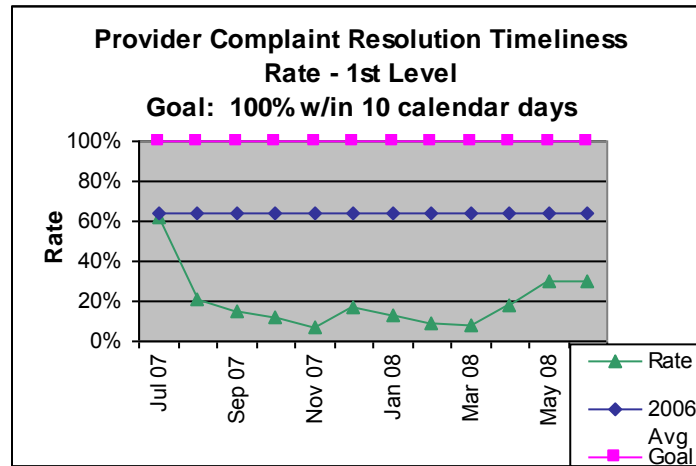
Provider Complaint Resolution Timeliness Rate - 1st Level
Goal: 100% w/in 10 calendar days

Source: Navigator

Provider Medical Grievance & Appeal Overturn Rate
Goal 15% or less

Source: Navigator

Source: Navigator

Provider Non-Medical Grievance & Appeal Overturn Rate Goal: 20% or less

Source: Navigator

Provider Grievance Resolution Timeliness- 2nd Level
Goal: 100% w/in 30 calendar days

Source: Navigator

Provider Appeals Resolution Timeliness- 3rd Level
Goal: 100% w/in 60 calendar days

Source: Navigator

355
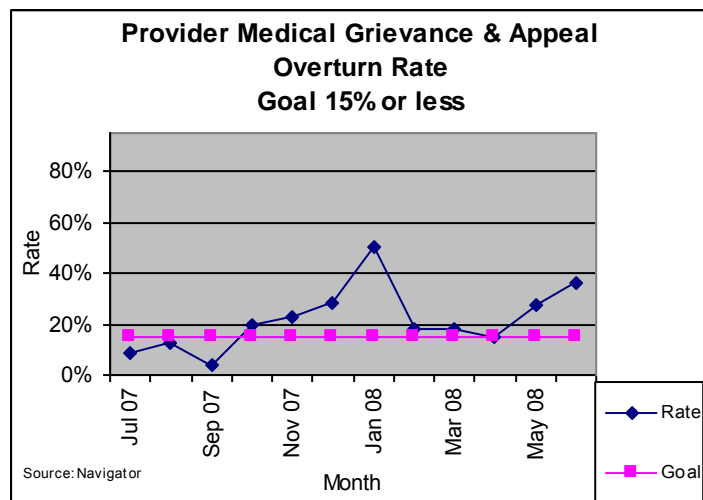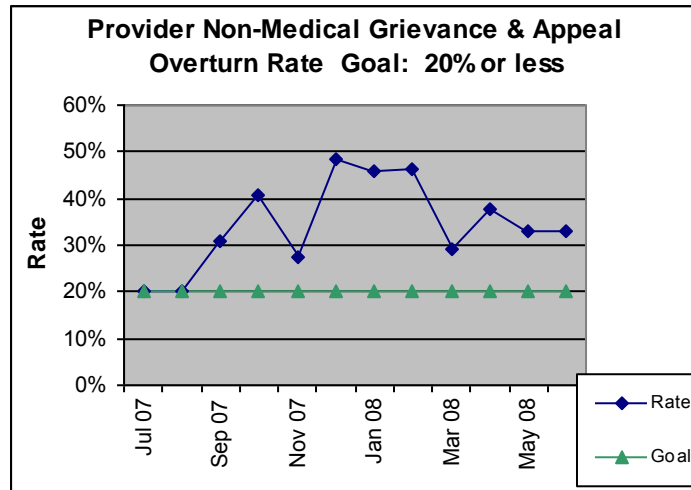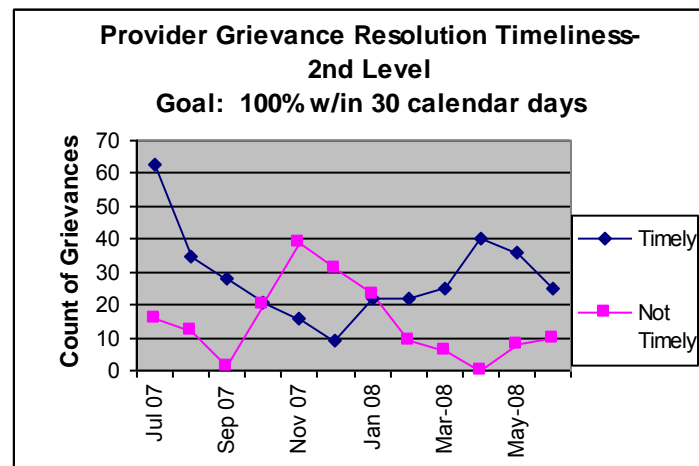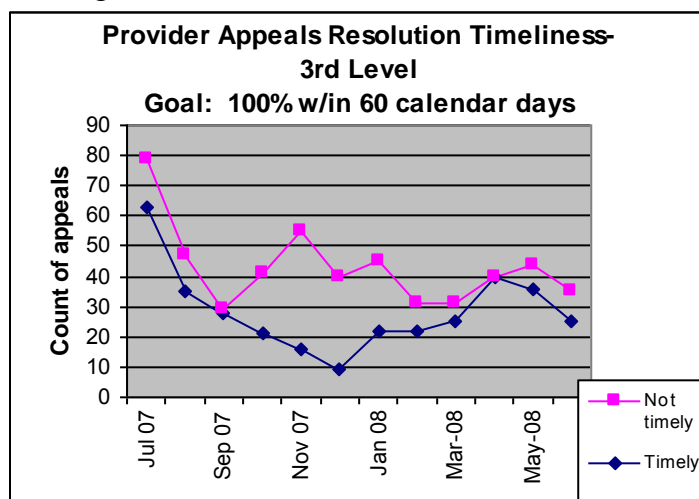
<u>Plan</u>
Grievance Tracking log has been updated with new additional categories to better identify specific issues above and beyond the categories listed and reported in the state database.

Confidentiality
HealthCare USA maintains written policies and procedures regarding member rights and protections and complies with all federal and state laws pertaining to those rights and protections, including confidentiality. HealthCare USA ensures staff and providers take those rights into consideration when furnishing services to HealthCare USA members. All staff are required to sign a confidentiality statement at the time of hire and every year thereafter. Member rights and protections are provided in the Member Handbook, as well as the Provider Manual and include the following:

Member Rights
- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment and the freedom of choice among network providers;
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected;
- Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member;
- Each member will be provided with names, locations, telephone numbers, and any non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients;
- Each member will be provided with information on grievance and fair hearing procedures;
- Each member will be provided with the amount, duration, and scope of benefits available under the contract to which they are entitled;
- Each member will be provided with information on how to obtain benefits,   including authorization requirements;
- Each member will be provided with the extent to which, and how, they may obtain benefits including family planning services, from out-of-network providers;
- Each member will be provided with the extent to which, and how, after-hours and emergency coverage are provided including:
  - What constitutes emergency medical condition, emergency services, and post stabilization services
  - The fact that prior authorization is not required for emergency services

- The process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent
- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services
- The fact that the member has the right to use any hospital or other setting for emergency care.
- Each member will be provided the post stabilization care services rules;
- Each member will be provided the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- Each member will be provided cost sharing information, if any, and;
- Each member will be provided information on how and where to access any benefits that are available.

Member Responsibilities

- Each member must provide, to the extent possible, information needed by providers in caring for the member;
- Each member must contact their primary care provider as their first point of contact when needing medical care;
- Each member must follow appointment scheduling processes; and
- Each member must follow instructions and guidelines given by providers.

Missouri Care

Provider Complaint, Grievance and Appeal Management
Providers receive information packets at the time of contracting with Missouri Care. The packets contain the complaint, grievance and appeals policies and procedures, specific instructions regarding how to contact the Provider Relations Department and identify the grievance coordinator who receives and processes complaints, grievances and appeals.

During SFY 08, 1,931 provider complaints, grievances and appeals were filed with Missouri Care. Of these, 518 were medical, 372 were behavioral health and 1040 were non-medical (claim issues and timely filing). The providers filed 1659 complaints, 218 grievances and 50 appeals. All complaints, grievances, and appeals are reviewed. In SFY 08, Missouri Care upheld approximately 63% of its original decisions.

Member Grievance and Appeals Management
Missouri Care evaluates and processes grievances and appeals filed by members according to applicable state of Missouri and federal statutes, regulations, contracts and policies. Members can file grievances in regard to any aspect of service, including those related to cultural sensitivity or sexual harassment. In no instance will a member be subject to any punitive action, including charges, for utilizing the grievance and appeal process.

Missouri Care maintains records of grievances and appeals for all MO HealthNet managed care members, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant or appellant, date of the grievance or appeal, date of the decision

and the disposition. The SIC conducts a quarterly review of the number of grievances filed by members and providers to determine if any trends exist. Any identified trends are referred to the appropriate department for review and any necessary education, training or corrective action. All identified trends will also be submitted to QMOC for review. Analyses of grievances are included in provider profiles for review at the time of recredentialing. Grievances are logged in the QNXT Call Tracking System to identify trends.

Eight appeals and 48 grievances were received from members during SFY 08. All issues have been
resolved. The plan's original decision was upheld in approximately 48% of the cases.

Confidentiality
Missouri Care has written policies and procedures for maintaining the confidentiality of data, including medical records, member information and appointment records for adult and adolescent STDs and adolescent family planning services.

The Missouri Care Notice of Privacy Practices provides a formal written description of how the plan may use and disclose protected health information (PHI). The notice explains members' rights to access, change, restrict or receive an accounting of disclosures of PHI. Missouri Care makes the Notice of Privacy Practice available to members in accordance with HIPAA distribution requirements. Additional copies are available to members or their representatives upon verbal or written request.

All marketing and educational materials maintain members' rights to confidentiality. Postcards are folded to protect the confidentiality of the members.

Molina Healthcare of Missouri

Provider Complaint, Grievance and Appeal Management
MHMO assures timely, fair and consistent provision of services to its providers with regard to any dissatisfaction resulting in the filing of a complaint, grievance or appeal. Through monitoring and tracking of provider complaints, grievances and appeals, MHMO is able to conduct investigations and improvement corrective action plans where necessary. The data below reflects the volume of provider complaints, grievances and appeals processed by MHMO during FY2008.

Provider Complaints	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
Complaints Received	587	665	628	1,388	3,268
Complaints Upheld	331	413	250	443	1,437
Complaints Overturned	243	252	358	936	1,789
Processed Timely	*	657	46	979	1,682

Provider Grievances	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
Grievances Received	97	72	42	161	372
Grievances Upheld	94	62	21	116	293

Grievances Overturned	2	10	20	44	76
Processed Timely	*	64	31	184	279

Provider Appeals	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
Appeals Received	13	5	9	27	54
Appeals Upheld	12	4	9	21	46
Appeals Overturned	1	1	0	4	6
Processed Timely	*	5	9	18	32

*Data unavailable at time of report

Member Grievance and Appeal Management

MHMO recognizes a member's right to file grievances and appeals and to request a State Fair Hearing at any stage of the grievance/appeal process. MHMO makes a concerted effort to resolve member grievances and appeals as expeditiously and fairly as possible. Below is data reflecting the volume of member grievances and appeals processed by MHMO during FY2008.

Member Grievances	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
Grievances Received	6	44	51	89	190
Grievances Resolved	0	43	51	89	183
Processed Timely	0	42	48	88	178

Member Appeals	1QFY08	2QFY08	3QFY08	4QFY08	FYTD
Appeals Received	2	15	5	0	22
Appeals Upheld	0	11	3	0	14
Appeals Overturned	2	11	2	0	13
Processed Timely	0	10	5	0	15

Confidentiality

MHMO complies with applicable federal and state regulations related to protecting the privacy of health information. Employees maintain confidentiality by securing member information in the work area; properly destroying reports and documents containing member information, and using discretion when discussing member information to avoid improper disclosure. Employees are required to sign a Non-Disclosure Agreement. New employees take two on-line HIPAA training sessions and all employees annually take HIPAA refresher courses.

This page intentionally left blank.

Utilization Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Utilization Improvement Program Scope
The Medical Management Program extends across all aspects of the healthcare delivery system, including inpatient services, outpatient services, ancillary services, home services, pharmacy services, new technology assessment, early intervention services, chronic disease management, self-care and prevention programs.

The Medical Management Program includes processes to measure, monitor, and optimize utilization of healthcare services in the above settings at the member and provider level.

Management processes used by the Medical Management Department include prospective, concurrent and retrospective review processes, pro-active case and care management and disease management programs. BCBSKC-BA+ has written medical management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, and concurrent, prospective, and retrospective review of claims that comply with federal and state laws and regulations, as amended to comply with MO State contract site 2.17.5b. The Program monitors and manages to achieve optimum utilization and seeks to identify and eliminate both under and over utilization.

The Medical Management Program improves effectiveness by communicating with other areas of the company that touch members and providers regarding utilization and case management issues. It works collaboratively with Quality Management, Customer Service, Membership, Provider Services, Legal, and others as needed. Medical management policies and procedures are clearly specified in provider manuals and are consistently applied in accordance with the established utilization management guidelines.

The Vice President and Senior Medical Director of Care Management for BCBSKC is the designated senior executive responsible for the implementation of the Medical Management Program. He is the chairperson of the Quality Council, sponsor of the Medical and Pharmacy Management Committee and is a member on other senior management committees. He receives information regarding the Medical Management Program from the Medical and Pharmacy Management Committee, medical reporting, physician advisory committees and monthly meetings with the Medical Management team. He delegates oversight of some aspects of the Program to the Medical Directors, as appropriate.

Discharges Per Year
Inpatient Visits
Average Length of Stay
Re-Admissions
Emergency Department Utilization
Outpatient Visits
Over/Under Utilization

UTILIZATION STATISTICS

Discharges Per Year	10.28 Per 1000 Member Months
Inpatient Visits	34.61 Per 1000 Member Months
Average Length of Stay	3.37Days
Emergency Department Utilization	66.78 Per 1000 Member Months
Outpatient Visits	309.66 Per 1000 Member Months

Inter-Rater Reliability
Inter-rater reliability of staff and medical directors include criteria selection and medical necessity decisions.

a. The inter-rater reliability activities for the medical directors focused on peer overturned denials on appeal. Review of overturned appeals revealed that the main reason for one medical director overturning another was the receipt of additional information. Other discussion points revolved around the interpretation of benefits, clarification of the reason for the denial, and medical policy interpretation.

b. A web-based inter-rater reliability tool with automated reporting is used by the concurrent review nurses. All concurrent review nurses take five cases per quarter. The goal of 90% was met amongst all concurrent review nurses.

Timeliness of Care Delivery
BA+ maintains a network of providers to assist the member accessing the care they need in a timely manner. The Member Handbook provides the member with specific information on access standards and when care is to be delivered. The Physician Office Guide provides the access standards the provider must keep. (Please see page 31 for metrics on our continuity and coordination of care.)
The 2008 Consumer Assessment of Health Plans (CAHPS®) survey indicates that members are able to access the care they need 81.6% of the time. BA+ rates exceed the CAHPS® benchmark and the 2007 BA+ rate.

Timeliness of Prior Authorization/Certification Decision Making
BA+ monitors the timeliness of nursing review staff and medical directors as it relates to prior authorizations, concurrent reviews and retrospective reviews.

a. The scores for timely decision-making were 90% or above for FY2008. The goal was met for timeliness.

The Utilization Management Department maintains policy and procedures that provide the mandated timeframes for responding to service authorizations.

Children's Mercy Family Health Partners

Utilization Management Program Objectives
- Ensuring that medical necessity and appropriateness of care are the paramount drivers in decisions made concerning the authorization of health care services to members.

- Ensuring effective utilization of resources for all hospital and ambulatory care by reviewing, monitoring, reporting and acting upon issues of over-utilization, under-utilization, and inefficient or inappropriate utilization of resources and services.

- Ensuring that members receive required and appropriate health care services by monitoring the appropriateness and medical necessity of admissions and continued stays, based upon application of nationally recognized criteria, and the provision of screening, prior authorization and concurrent reviews for hospital admissions and certain outpatient procedures.

- Monitoring and assisting in the promotion, maintenance and assurance of high quality care in all areas, through prospective, concurrent and retrospective review, and the application of quality indicators to identify possible quality assurance concerns related to Utilization Management.

- Reviewing and monitoring the appropriateness and medical necessity of durable medical equipment, home health care, and other home health services.

- Assuring systematic data collection, analysis, and evaluation of performance and member results.

- Assuring the presence of a program of utilization review and that such is a collaborative effort by the physicians and other health professionals, which includes interpretation of data analysis and implementation of change when needed to practitioners.

- Provide timelines for correction/corrective action plans and assign specific health plan staff to monitor compliance and follow up.

- Assessing, coordinating and monitoring appropriate discharge planning needs, and assuring that Case Management is aware of all who have ongoing or special needs.

- Establishment of protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims to comply with federal and state laws and regulations.

- Consistent application of policies and procedures, which are clearly specified in provider contracts and/or manuals.

- Identification of over and under utilization for inpatient and outpatient services and appropriate actions to correct issues and follow up.

- Coordination of services for both covered and non-covered benefits

- Coordination of school based clinic services with benefits provided by the Plan

- Ensuring that provider and subcontractor compensation is not structured so as to provide incentives for the provider or subcontracted vendor to deny, limit, or discontinue medically necessary services to any member.

- Provide regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.

Utilization Improvement Program Scope
The following covered services are monitored under the Utilization Management Program:
    Ambulatory Services
    Case Management Services
    Certified Nurse Midwife Services
    Core services provided by Local Public Health Departments
    Corneal Transplants
    Dental Services
    Diabetic Self Management Services and Training
    Durable Medical Equipment
    Emergency Room Services
    Emergent and Non-Emergent Transportation
    Hearing Aides and related Services
    Home Health Services
    Home Medical Equipment
    Hospice Services
    Inpatient Services
    Pre and Post Transplant Services for solid organ and stem cell transplants
    Laboratory, Radiology, and other diagnostic Services
    Mental Health Services
    Nurse Advice Utilization and Outcomes

Personal Care Services
Physician and Advanced Practice Nursing Services
Podiatry Services
SAFE-CARE Exams (in-network or out-of-network)
Transplant Services (other than corneal or kidney): before and after admission for transplant, including evaluation (in-network and out-of-network, per members choice)

Utilization Management Program Organization
Children's Mercy Family Health Partners' (CMFHP) Board of Directors is ultimately responsible for Utilization Management activities. Utilization Management activities are reported to the Board of Directors by the Chairperson of the Medical Oversight Committee or CEO at least annually.

The Chief Clinical Officer and Medical Directors are responsible for implementation of the Utilization Management Program, under the supervision of the Chief Executive Officer.

The Chief Executive Officer, or his/her designee, ensures that the departments and Medical Directors fully support and participate in the Utilization Management Program. In addition, the Chief Executive Officer will ensure that the Utilization Management Program will be developed and implemented by professionals with adequate and appropriate experience in quality assessment, quality improvement, utilization management, and continuous improvement processes.

The Medical Oversight Committee evaluates the program activities on at least an annual basis.

The Medical Directors are responsible for oversight of the Utilization Management Program and annual approval of the Utilization Management Program and related policies. The Medical Directors' responsibilities regarding Utilization Management include:

- Assure compliance with applicable state, federal, or contractor/purchaser Utilization Management Standards as described in applicable statute or HMO product contract.

- Participate in implementation, monitoring, evaluation and developing improvement of the Utilization Management Program.

- Serve as liaisons between the health plan and the network providers.

Discharges Per Year

Inpatient Visits
July 1, 2007 to June 30, 2008, Children's Mercy Family Health Partners experienced an overall 3% increase in the number of inpatient cases. The pediatric hospitalizations increased by 2% and adult hospitalizations increased by 4%. Obstetrical cases remained constant during this timeframe.

Inpatient Days/1000 members per year

July 1, 2007 to June 30, 2008, inpatient days per 1000 members decreased by 13%. Pediatric days per 1000 members decreased by 19% and adult days per 1000 members decreased by 4%. Obstetrical days per 1000 members decreased by 11%.

Average Length of Stay

July 1, 2007 to June 30, 2008, the average length of stay for all hospitalized members decreased by 4%. For adult members, the average length of stay increased by 4% and for pediatric members, the average length of stay decreased by 10%. Inpatient obstetric length of stays remained constant during this timeframe. Seasonal variations may affect the trend when looking only at a calendar year of data, therefore, average length of stay is not considered a primary indicator of inpatient performance. Rather, Children's Mercy Family Health Partners looks at overall days per thousand members as a more accurate indicator of reducing unnecessary inpatient costs.

Re-Admissions

Children's Mercy Family Health Partners (CMFHP) reviews a monthly report of readmissions to the hospital with the same diagnosis within 30 days of discharge. This report is currently being used by the Care Managers and Utilization Review nurses as a tool to identify premature discharge, poor discharge planning, failed outpatient treatment, or non-compliance issues. If an issue is identified related to potential premature discharge or poor discharge planning, the case is referred to the Quality Management department for investigation using CMFHP's quality of care investigation process. If the readmission is determined to be a result of member non-compliance with the treatment plan, case management is initiated in an attempt to educate the member and reinforce the treatment plan established by the member's physician.

Emergency Department Utilization
Outpatient Visits

	Qtr1	Qtr2	Qtr3	Qtr4	Total 2007	Total 2006	%Chg
Member Months	125,559	129,733	131,312	132,401	519,005	511,689	1%
Outpatient Medical Cost Incurred							
Emergency Room - All	2,704,113	2,849,615	3,120,149	3,517,041	12,190,918	9,931,005	23%
Outpatient Hospital	5,144,180	5,323,046	5,290,451	5,404,374	21,162,051	18,050,464	17%
Grand Total	7,848,293	8,172,661	8,410,600	8,921,415	33,352,969	27,981,469	19%
Outpatient Visits							
Emergency Room - All	7,359	7,450	7,902	9,090	31,801	31,347	1%
Outpatient Hospital	21,607	21,072	21,328	20,775	84,782	87,828	-3%
Grand Total	28,966	28,522	29,230	29,865	116,583	119,175	-2%

Visits per 1000 Members							
Emergency Room	703	689	722	824	735	735	0%
Outpatient Hospital	2065	1949	1949	1883	1960	2060	-5%
Cost per Visit							
Emergency Room	367	382	395	387	383	317	21%
Outpatient Hospital	238	253	248	260	250	206	21%
Grand Total	271	287	288	299	286	235	22%

Over/Under Utilization
Children's Mercy Family Health Partners (CMFHP) monitors over and under utilization through a variety of reporting mechanisms on a monthly and quarterly basis. CMFHP contracts with an organization called ManagedCare.com. This organization compiles data submitted by CMFHP and prepares various utilization statistics for review at all levels (provider, facility, type of service, procedure, etc.). The database compares CMFHP's data to other similar populations in the database to establish a mean for any particular service. Use of this analysis allows CMFHP's management team to identify areas where providers are outliers among their peers.
CMFHP continues a semi-annual report card to physicians, using the ManagedCare.com data compiled, comparing each physician's medical utilization data to that of his or her peer group. The report card is an informational tool for the physicians to identify if practice variances or opportunities for improvement exist.

Through the monthly utilization reporting, as well as medical claims payment reports, CMFHP is able to identify areas of over or under utilization.

Inter-Rater Reliability
The Health Services department at Children's Mercy Family Health Partners (CMFHP) performs audits of Pre-certification personnel, Inpatient Review Nurses, and Care Managers to measure consistency in staff's documentation and clinical decision making. The process involves review of a random sampling of cases per staff member per quarter by the Manager of Clinical Services and Manager of Utilization Management. A tool is completed on each case to identify areas of deficiencies against the documentation standards. Managers review the audit results with their employees in a one on one meeting. Weekly complex case rounds are conducted as a way for Care Managers to collaborate on cases and enhance knowledge about complex care coordination and available resources. The Utilization Review Nurses can meet with the Medical Director on a daily basis to review current inpatient cases and discuss application of criteria for consistency in decision-making.

In 2007, an inter-rater reliability process was established for the Medical Directors at CMFHP as a way to measure application of clinical criteria and judgment. The process is completed on a quarterly basis and is intended to identify opportunities for improved consistency in decision-making.

The Quality Management department at CMFHP performs inter-rater reliability on the HEDIS hybrid medical record abstraction process, the Primary Care Provider medical record review process, and the complaints/grievances/appeals process. In addition, the Quality Management department implemented an auditing tool to measure consistency in staff documentation and processing of member grievances and appeals and provider complaints, grievances and appeals. The audit outcomes have identified opportunities for ongoing improvement and staff education.

Timeliness of Care Delivery
Timeliness of Prior Authorization/Certification Decision Making
A monthly key indicator measurement is an indication of turnaround time on utilization management decisions. Each request is tracked for meeting standard timeframes for decision-making. Routine services require a 3 day turnaround for making a decision after all necessary information is received. Urgent services require a 24 hour turnaround time. In 2008, the average timeframe for decision-making on both inpatient and outpatient service requests was 1 day.

Harmony Health Plan of Missouri

Utilization Improvement Program Scope
PROGRAM EVALUATION FOR 2007-2008
The Utilization Management Annual Program evaluation presents an analysis of Utilization Management and Health Services operational goals as outlined in the Utilization Management Program Description. This evaluation identifies area trends related to process, impact, and outcomes as follows:

1) Monitoring utilization activity against health plan goals and objectives established through the Utilization Management Program Description.

2) Objective measures are analyzed to evaluate whether medically necessary services are delivered at appropriate levels of care and that services rendered correlate with the benefit package coverage.

3) Ensures that efficient processes are in place and working effectively to improve quality while monitoring for over and under utilization trends.

4) Ensures compliance with regulatory and accrediting bodies.

Focus for 2007-2008
- Implemented quality bed-day management by improving appropriate utilization trends: targeting an overall goal of 646 bed-days/1000, and a < 3% increase in readmission rate.
- Enhance Disease and Case Management Programs.
- Assess the results of focused case management programs and determine rollout schedules.
- Coordinate quality improvement efforts with Network, PR, Regions, and IT tomeet regulatory requirements.
  - ➢ Implemented Peer-to-Peer Reconsideration Process

- ➢ Reviewed, updated and improved initial denial letters and workflow process
- Continued to improve operational effectiveness and efficiency through business process reengineering and automation.
  - ➢ Implemented improvements to authorization request process to assure timeliness of decisions based on type and priority of requested service.
  - ➢ Implemented standardized documentation requirements and auditing process for authorization decisions.
  - ➢ Improved corporate UM decision tools within each UM team to ensure adherence to market specific business rules.

Evaluation:
WellCare utilized an authorization metric report to evaluate attainment of quality bed-day utilization trends.

- For 2007, the YTD bed-days/1000 was an over all 823.49, and in the first six months of 2008 YTD is 631.72 showing a 23.3% decrease trend in bed-day/1000 utilization.
- For the same period, there was a 1% increase in readmission rates.
- Various types of confinement and utilization data are obtained to ensure utilization measures are reviewed regularly and performance measures are trended to identify over and under utilization patterns.

WellCare Utilization Management established focused goals targeted to control utilization activities through process improvement strategies. These process improvement strategies have been successful and WellCare attained set goals for bed-days/100 and readmission rates.

Process Improvement-Service Initiatives
Utilization Management implemented a peer-to-peer review process for initial denial notifications. This process was put into place to ensure that treating physicians are notified and can contact the Plan Medical Director and review a denial of a requested service. This process ensures appropriate decisions to deny services. The initial denial letters have been revised and process improvements have been made to ensure regulatory timeframes are met per contractual requirements. In addition, Utilization Management leadership tracks utilization performance on a monthly basis through an authorization turn around time report. Performance is monitored by approval turn around times, denial turn around times, and documentation for both outpatient and inpatient services. These reports serve a two-fold purpose: ensures that authorization requests are processed within regulatory and contractual timeframes, and serves to recognize process improvement opportunities for Utilization Management processes.

Utilization Management has standardized Inter-relater reliability training and assessment to ensure associates involved in authorization decision are making appropriate medical necessity review decisions. All Utilization Management, including prior authorization, concurrent review, and appeal review staff, have participated in InterQual training through instructor lead training, pre-assessments, and final assessments. The results of the final assessments documented a 100% pass rate with a consistent passing score of 80% or higher.

<u>Cultural Competency</u>
WellCare has developed a Cultural Competency Plan to ensure services and materials are provided in a culturally competent manner to all enrollee. The Cultural Competency Plan addresses how WellCare ensures that will meet the diverse needs of the population and all members through:

- Recruitment of a diverse health plan staff.
- Recruitment of a diverse provider network.
- Member Materials are developed and distributed that meet readability and
- linguistic needs of the population.
- Language translation services are available.
- Hearing and Blindness assistance is available.
- Partnering with community services to promote culturally-based support system
- that meets the needs of the population.

The Cultural Competency Plan will be evaluated through provider performance monitoring and plan self-assessments and reviewed annually to ensure compliance with the plan objectives. The Cultural Competency Plan is reviewed in depth in Sec. 5.0 of this evaluation.

<u>Health Profile</u>
Utilization Management tracks utilization through an authorization metric report that analyses bed-days/1000, admits/1000 and Average Length of Stay of inpatient hospitalization. The authorization metric report allows us to evaluate trends in services.

The most common diagnoses for inpatient hospitalizations during the evaluation period were: pregnancy related, newborn and neonate related, respiratory related, digestive related, and endocrine related. The most common hospitals utilized during the evaluation period were St. Mary's Health Center, Barnes-Jewish Hospital, DePaul Health Center, Cardinal Glennon Children's Hospital, and St. Louis Children's Hospital.

Over/Under Utilization
WellCare utilizes a monthly Authorization Metric Report to evaluate over utilization and underutilization trends. A market comparison is conducted that evaluates market utilization measures and compares health care delivery to ensure a consistent pattern of health care delivery. From this Metric Report, a market variance is obtained and establishes an indicator for over utilization and under utilization patterns.

Through analysis of these metrics, WellCare has established that patterns of health care delivery for Harmony Health Plan of Missouri, Inc. indicated a decrease in overall overutilization from previous years. Through process improvements, WellCare was able to decrease the over utilization, indicated by a decrease in bed days/1000 in a population where the catastrophic rate increased by 12.6%.

Discharges Per Year
Inpatient Visits
Average Length of Stay
Re-Admissions
Emergency Department Utilization
Outpatient Visits

Authorization Metrics MO 2007.ppx of monthly authorization (Reporter)
Dates of Service thru June
Wednesday, November 05, 2008 4:05:30 PM

11/5/2008 16:05

2008,Medicaid,Missouri,All IPA,All Confinement Types,All Companies,All Month Names,
All Observations Flag,IPA and Non IPA,All Reform Status,MEASURES

		MO			WellCare	Var
		YTD-08	YTD-07	Trend	YTD-08	WellCare
All Confinement Types	Member Months	96,806	28,348	241.5%	8,819,688	
	Admits	1,568	633	147.7%	99,515	
	Days	5,070	1,936	161.9%	318,758	
	Days/1000	631.72	823.49	-23.3%	435.94	44.9%
	Admits/1000	195.37	270.04	-27.7%	136.1	43.5%
	ALOS	3.23	3.01	7.3%	3.2	0.9%
	Denial Rate	1.22%	0.94%	0.3%	2.10%	-0.9%
	Catastrophic Rate	42.03%	29.46%	12.6%	33.49%	8.5%
	Readmit Rate	6.19%	4.56%	1.6%	5.69%	0.5%
Med Surg Total	Admits	970	372	160.8%	58,569	
	Days	2,674	904	195.8%	159,713	
	Days/1000	333.18	384.68	-13.4%	218.43	52.5%
	Admits/1000	120.86	158.68	-23.8%	80.1	50.9%
	ALOS	2.76	2.32	18.9%	2.73	1.1%
	MID Rate	1.38%	1.89%	-0.5%	3.38%	-2.0%
	Catastrophic Rate	46.51%	29.69%	16.8%	32.38%	14.1%
	Readmit Rate	7.84%	4.83%	3.0%	6.38%	1.5%

Births	Admits	447	229	95.2%	34,862	
	Days	1,354	655	106.7%	105,648	
	Days/1000	168.71	279.76	-39.7%	144.49	16.8%
	Admits/1000	55.7	97.77	-43.0%	47.68	16.8%
	ALOS	3.03	2.86	5.9%	3.03	0.0%
	MID Rate	0.00%	0.00%	0.0%	0.02%	0.0%
	Catastrophic Rate	1.62%	4.43%	-2.8%	7.06%	-5.4%
	Readmit Rate	3.36%	2.28%	1.1%	4.23%	-0.9%
Behavioral Health	Admits	114	0	0.0%	2,903	
	Days	524	0	0.0%	12,349	
	Days/1000	65.29	0	0.0%	16.89	286.6%
	Admits/1000	14.2	0	0.0%	3.97	257.7%
	ALOS	4.6	0	0.0%	4.25	8.2%
	MID Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Catastrophic Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Readmit Rate	0.00%	0.00%	0.0%	0.00%	0.0%
NICU	Admits	32	28	14.3%	2,367	
	Days	445	265	67.9%	34,621	
	Days/1000	55.45	112.17	-50.6%	47.35	17.1%
	Admits/1000	3.99	11.92	-66.5%	3.24	23.1%
	ALOS	13.91	10.98	26.7%	14.63	-4.9%
	MID Rate	2.47%	0.00%	2.5%	1.01%	1.5%
	Catastrophic Rate	87.42%	71.87%	15.6%	83.95%	3.5%
	Readmit Rate	18.75%	14.98%	3.8%	19.05%	-0.3%
Rehab	Admits	3	4	-25.0%	136	
	Days	68	112	-39.3%	2,220	
	Days/1000	8.47	46.88	-81.9%	3.04	178.6%
	Admits/1000	0.37	1.68	-77.9%	0.19	94.7%
	ALOS	22.67	9.11	148.8%	16.32	38.9%
	MID Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Catastrophic Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Readmit Rate	0.00%	0.00%	0.0%	0.00%	0.0%
SNF	Admits	2	0	0.0%	76	
	Days	5	0	0.0%	1,279	
	Days/1000	0.62	0	0.0%	1.75	-64.6%
	Admits/1000	0.25	0	0.0%	0.1	150.0%
	ALOS	2.5	0	0.0%	16.83	-85.1%
	MID Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Catastrophic Rate	0.00%	0.00%	0.0%	0.00%	0.0%
	Readmit Rate	0.00%	0.00%	0.0%	0.00%	0.0%

Inter-Rater Reliability
Harmony provided a copy of "InterQual Care Planning Imaging Criteria (Adult and Pediatric) Interrater Reliability (IRR) Tool along with Medical Director IRR Exercise results. Prior Authorization Core IRR scores were also provided.

Timeliness of Care Delivery
Response not found in Harmony's annual report.

Timeliness of Prior Authorization/Certification Decision Making
Response not found in Harmony's annual report.

HealthCare USA

Utilization Improvement Program Scope

The Concurrent Review staff are charged with the consistent application of nationally recognized and/or community physician developed decision support tools/protocols, timely and appropriate discharge planning, and coordination of alternative care arrangements for acute admission and/or observation stays, and arranging referrals to complex case management or disease management when appropriate.

The staff review each hospital admission using nationally recognized InterQual criteria and/or community physician developed decision support tools/protocols. Staff are responsible for ensuring consistency of services/procedures with guideline application; timely and appropriate discharge planning; coordination of alternative care; and arranging referrals to case management, complex case management or disease management when appropriate.

Almost all indicators for utilization increased in the first quarter 2008, in conjunction with the increased membership due to the county expansion. Second quarter 2008 rates declined from first quarter 2008, in many instances to baseline or below.

Discharges Per Year

The count of discharges reflected the rate of inpatient visits as shown below. Their was an increase in first quarter 2008, with a decrease to baseline in the second quarter of 2008.

Discharges

Source: referrals from IDX

373
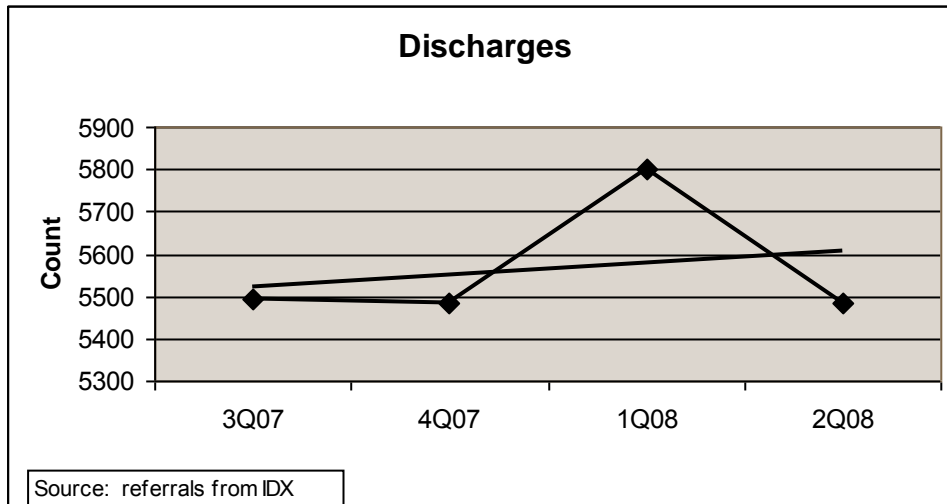
Inpatient Visits

Overall, the rate of inpatient admits has increased slightly during FY 2008. First quarter 2008 saw a sharp incline in conjunction with increased membership from the county expansion.

Inpatient Admits/1000

Source: Claims/referrals from MET Cube
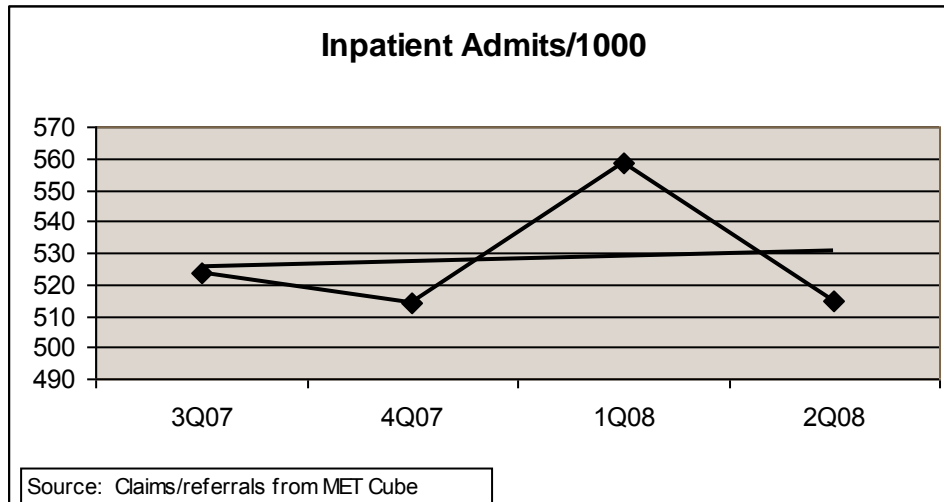
Average Length of Stay

The average length of stay in days has declined overall, despite an increase in the rate of inpatient admissions.

Average Length of Stay

Source: Claims from CDW
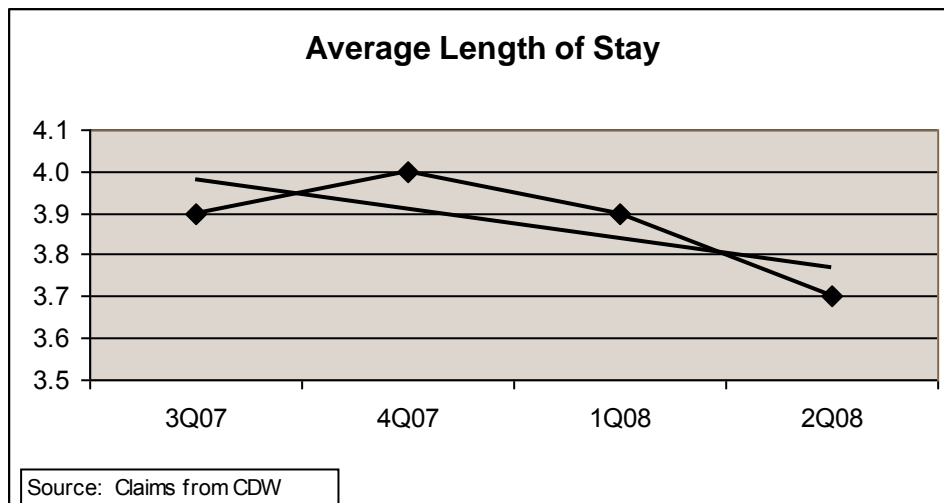
Re-Admissions

The readmission rate has declined overall during fiscal year 2008. HealthCare USA is in the process of revising a performance improvement project to more accurately reflect overall readmission rates and these rates for specific populations, such as members with asthma and members with diabetes. This project includes completion of morbidity assessments to evaluate reasons for readmissions and identify any trends and/or actionable items to prevent readmissions from occurring. Revisions to the project are planned to be fully implemented in January 2009.

Readmission Rate

Source: Cognos Cube
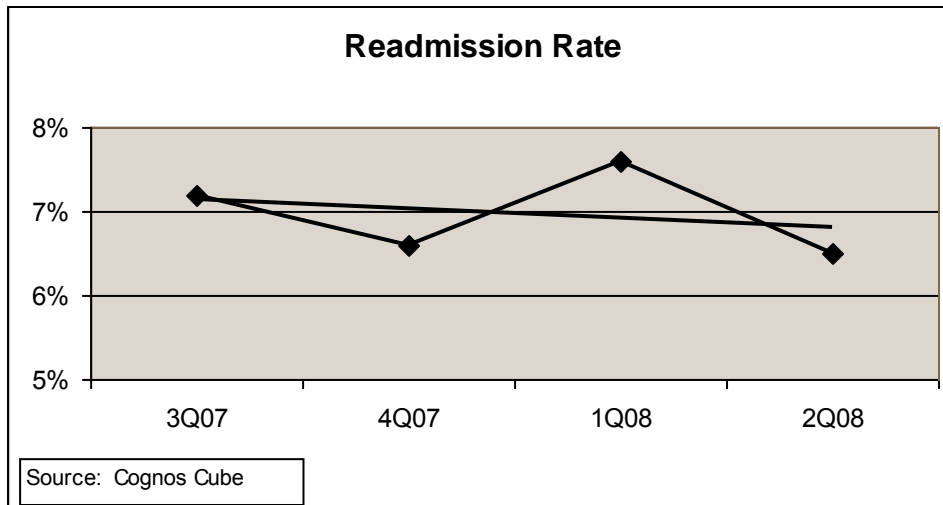
Emergency Department Utilization

Emergency department utilization increased through FY 2008. First quarter 2008 increase is most likely related to increased membership from the county expansion. HealthCare USA continues a Performance Improvement Project and interdepartmental workgroup to address over-utilization of the ED.

Emergency Department Utilization

Source: Claims/referrals from MET Cube
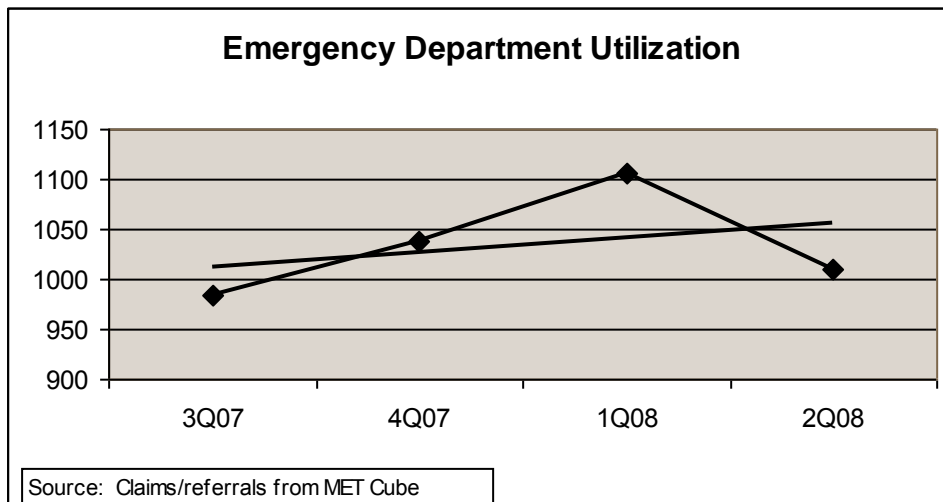
Outpatient Visits

Hospital outpatient visits increased overall through FY 2008, peaking in first quarter 2008, with the county expansion.

Hospital Outpatient Visits/1000

Source: Claims/referrals from MET Cube
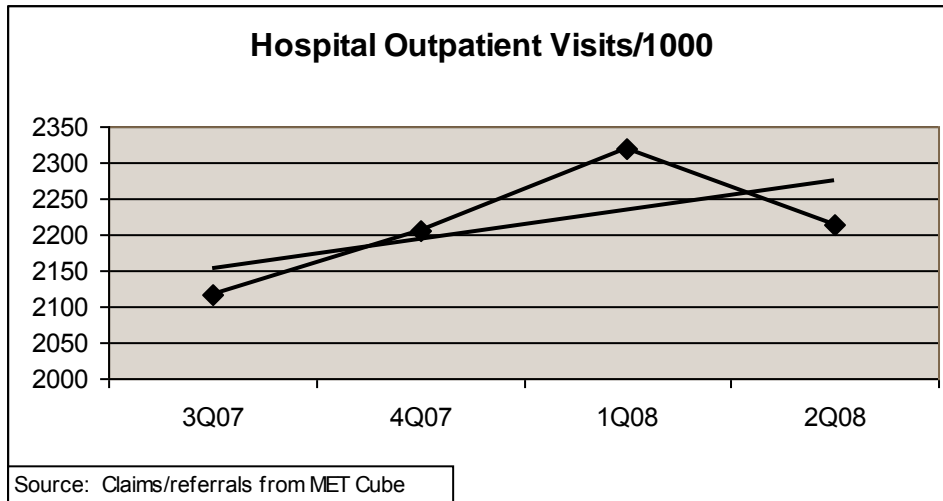
Physician Services

Physician services utilization also increased and spiked in first quarter 2008 with the county expansion.

Physician Services Utilization

Source: Claims/referrals from MET Cube
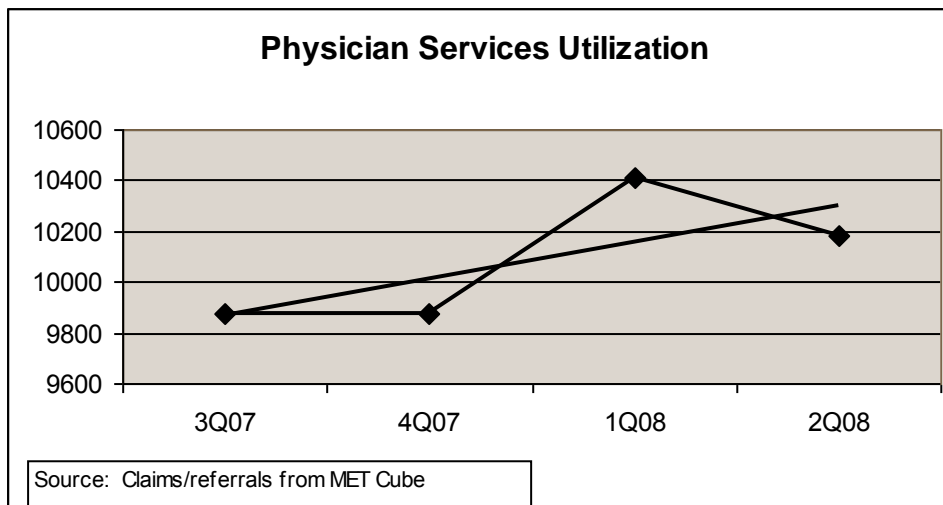
Over/Under Utilization

HealthCare USA conducts continuous monitoring for over and under utilization of services through the analysis of claims and referral data. Many opportunities for improvement have been identified. Areas in which HealthCare USA is currently working on improving over utilization include Emergency Department (ED) Visits and readmissions. As a part of the ED project, pain management and narcotic abuse are being assessed. The Pharmacy has a lock in program for members suspected of or exhibiting drug seeking behaviors or abuse. Areas of improvement for under utilization include EPSDT visits, prenatal and postpartum care, and asthma care.

HealthCare USA continues the Beary Important Bundle Prenatal visit member incentive program to encourage pregnant members to attend their prenatal visits per their OB healthcare provider's instructions. This has proven to be very successful and well received, and HealthCare USA continues to share this program with the membership through brochures, the member newsletter and through high volume provider offices. Utilization of this program will continue to be monitored. See Performance Improvement projects – Clinical for more information.

HealthCare USA established an Asthma Around the World member incentive program to encourage members with asthma to attend their visits with their asthma healthcare provider, obtain their asthma medications and identify a rescue person, provide the rescue person with their asthma action plan for daycare, school or work. In addition, a provider education code was established to reimburse those asthma healthcare providers for setting aside time to complete asthma education to members as the provider deems appropriate. Utilization of this program will be tracked through submitted claims. More information on these programs can be found in the Performance Improvement Projects section of this report.

Inter-Rater Reliability
All physicians and nurses involved in utilization of services activities received InterQual training and participate in routine inter-rater reliability audits. The purpose of Medical Director and nursing peer to peer audits is to improve knowledge of newer/less experienced staff and improve consistency with determinations made.

All Coventry Medical Directors routinely audit a sample of the Health Plan's medical review determinations to ensure that they are consistent, meet the Plan's policies and procedures, and are in compliance with applicable InterQual criteria or Coventry technical recommendations. The outcomes of the reviews are educational in nature and do not impact the decision previously rendered. During FY 2008, each Medical Director reviewed 5 cases every six (6) months. Consensus was achieved on all the cases post-test and the applicable InterQual criteria and Technology assessments were reviewed and agreed upon.

The health services staff also conduct peer to peer audits on a monthly basis. Five cases are randomly selected for each staff member and reviewed for accuracy, completeness and timeliness of decisions made. Cases are also reviewed to determine if appropriate referrals are made to case managers and/or disease managers. The details of the audits are described in Plan policy.

The quality improvement clinical staff conduct peer to peer documentation and inter-rater reliability audits on disease management cases. A tool was developed to assess these cases and both the disease managers and quality improvement staff conduct these reviews on a monthly basis and discuss outcomes at least quarterly.

Timeliness of Care Delivery
HealthCare USA utilizes the Coventry Member Reminder System to notify members who are in need of preventive and well care services. The system generates reminders for members who are in need of receiving necessary preventive services. In addition to this system, lists for providers

of members on their panel who are in need of these services are also generated in addition to provider HEDIS reports cards to improve coordination and collaboration with providers to increase member adherence to preventive and well care services.

The following Preventive and Care Management reminders were sent in FY 2008:
- Childhood immunizations/lead (Coventry Birthday reminders and adherence reminders if no claim for services is identified)
- EPSDT (Coventry birthday reminders and adherence reminders if no claim for services is identified)
- Pharmacy claims review by Disease Management staff and outbound calls to members with asthma or diabetes who have no claims for routine medication refills.

An opportunity to improve the member reminder system and a pilot with a CSO to use the Coventry Navigator system to identify members in need of preventive services at the time of a member call to the CSO was completed. Specific phone scripts, member training and resolution of IT issues is in the process of being resolved with an anticipated membership wide implementation by the end of 4th quarter 2008.

HealthCare USA has continued to improve the EPSDT overall participation ratios. There has been a steady increase in the EPSDT ratios since 2000. This is identified through the participation rates reported by the State agency as well as the decrease in the EPSDT penalty applied to the capitation rate.

Calendar Year	Overall Participation Rate
2000	58.36%
2001	61.66%
2002	69.33%
2003	69.66%
2004	72.50%
2005	65.09%
2006	68.58%
2007	76.00%

During case reviews, concurrent review staff determine if care provided in the hospital is delivered in a timely manner. They refer cases to the medical director and the QI staff if there is some concern regarding the care being provided. Staff begin evaluating for discharge needs at the time of the admission. They make arrangements for any home health or DME needs prior to discharge to facilitate the timely delivery of care after discharge.

Timeliness of Prior Authorization/Certification Decision Making
HealthCare USA manages the prior authorization/certification process to guarantee that we follow all time restrictions on requests. In all cases, if the determination is not made within the timeframes allowed, automatic approval is given.

For elective requests, the following timeframes are maintained: Approval or denial of non-emergency services when determined as such by emergency room staff is provided by

HealthCare USA within thirty (30) minutes of request. Approval or denial is provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider. For requests to extend a current course of urgent care treatment, decisions are issued within twenty-four (24) hours. Approval or denial is provided within two (2) business days of obtaining all necessary information for routine services. In no case will HealthCare USA exceed fourteen (14) calendar days following the receipt of the request for service to provide approval or denial.

For certification review, initial determinations will be provided within two (2) working days of obtaining all necessary information. Concurrent review determinations are provided within one (1) working day of obtaining all necessary information. When additional information is needed, the provider is notified within two (2) business days following the receipt of the request. All requests for services are answered within fourteen (14) calendar days of the receipt of the request for initial or concurrent review determinations.

UM Decision Making Timeframes Within 2 and 14 Days

IDX Referrals
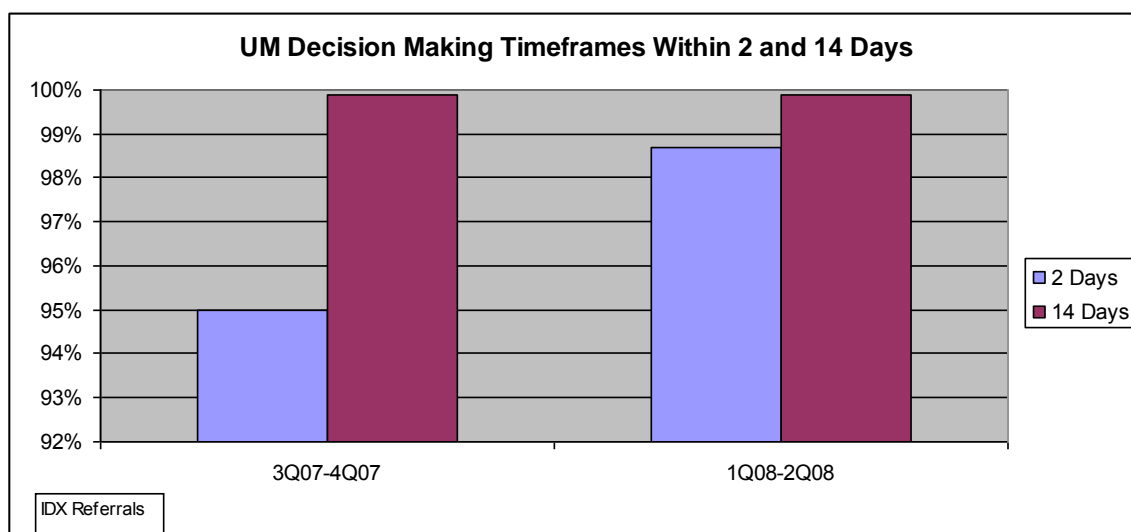
HealthCare USA continued efforts in educating providers and facilities on the benefits of submitting authorization requests via WebMD. Utilization of WebMD has been instrumental in reducing call volume for the preauthorization department. This project not only reduced call volume, but also improved calls abandoned and service quality.

Percentage of Total Preauthorization Referrals From Web MD

Source: IDX

Count of Preauthorization Referrals

Source: IDX
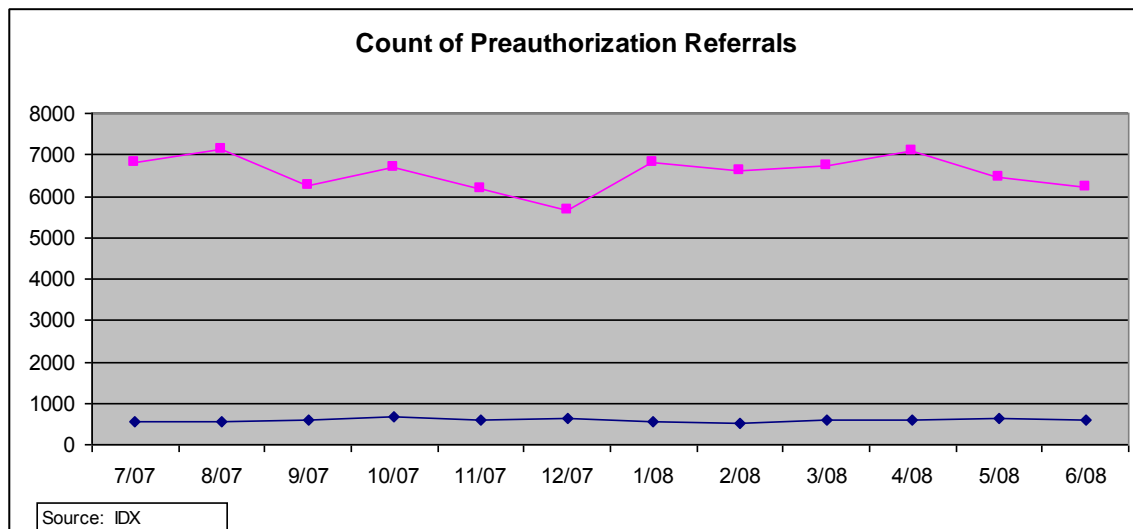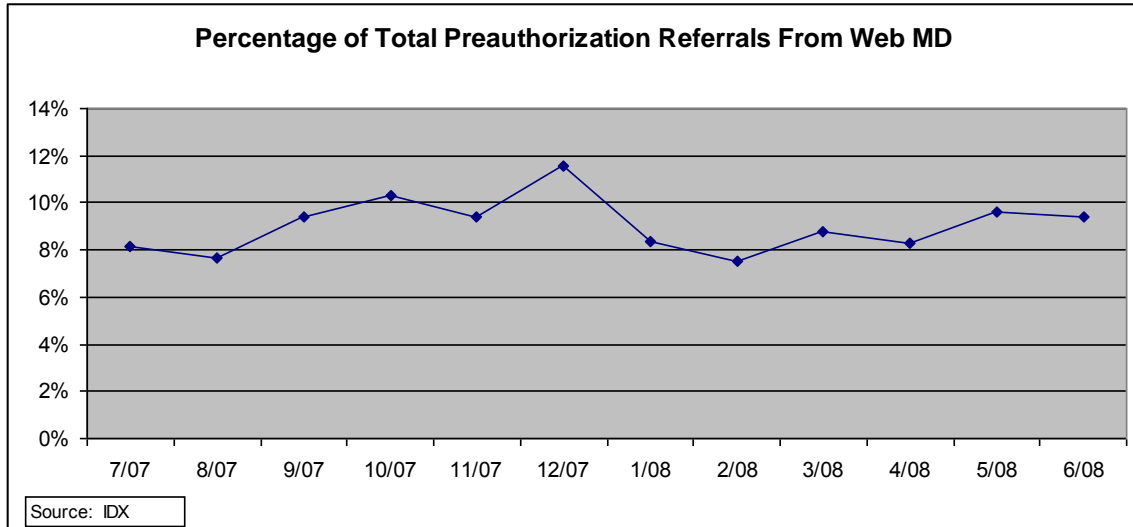
Missouri Care

Utilization Improvement Program Scope
Missouri Care's Utilization Management Program was established to integrate systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program was designed to assist members and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes and manage costs.

The utilization management program is integrated with Missouri Care's Quality Management Program and pursues the plan's common principle of ensuring high quality, cost-effective, outcomes-oriented health care by balancing clinical/medical management, operations and finance components.

The purpose of the Utilization Management Program is to manage the use of health care resources so that members receive the most medically effective and cost effective health care that will improve their health outcomes. Missouri Care believes that integrated utilization processes provide the environment for optimal utilization of care and services by members and health care professionals and providers.

The utilization management program objectives are:
- To maintain systems for identifying member and health care professional/provider utilization and/or practice patterns
- To manage referrals for medical services in order to maintain continuity of care and the effective use of medical resources
- To monitor benefit coverage, medical necessity, appropriateness of services and setting, and compliance with regulatory requirements
- To identify members and/or populations whose care may benefit from case management interventions
- To maintain integrated systems and processes for collecting utilization data and disseminating information through the health care professional/provider network and regulatory agencies, which may require special reports
- To use disease management practice guidelines to improve outcomes for members and special populations, such as the aged or the developmentally disabled
- To maintain culturally competent practices throughout the plan and its network of health care professionals and providers
- To evaluate provider/member satisfaction with the utilization process and develop strategies for improvement
- To work with health care professionals, providers, members, their families and caregivers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources
- To develop utilization benchmarks, initiatives and target outcomes that reflect the plan's strategic expectations, directions, and goals and comply with federal, state, and local regulations and requirements

- To identify patterns of individual or systemic over- and underutilization and develop ways to address them
- To maximize the utilization of appropriate resources to improve a member's outcome or control a condition

The Missouri Care Utilization Management Plan applies to:

- All members enrolled in Missouri Care
- All covered services provided to members through contracted or non-contracted health care professionals and providers
- All contracted or non-contracted health care professionals and providers who deliver care or services to members
- All sites and facilities in-state and out-of-state (including ancillary providers) at which contracted and/or non-contracted health care professionals provide care or services to members
- All processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage and medical appropriateness, including:
  - o Utilization management processes and functions: prior authorization, concurrent review, case management, disease management, medical claims review, referral management, discharge management
  - o Utilization monitoring processes (e.g., HEDIS, or others required by state regulatory or review agencies, or the plan; drug utilization reviews; physician profiles)
  - o Performance monitoring processes (e.g., inter-rater reliability, telephone answer time, abandonment rates, productivity)
  - o Evaluations of outcomes data

The Missouri Care Quality Management Oversight Committee (QMOC) has final accountability for the Utilization Management Program and related processes, activities and systems. The operating board delegates authority to the Chief Executive Officer (CEO) for allocating financial and employee resources to carry out the program. The CEO delegates authority and accountability for implementing and maintaining the Utilization Management Program to the Senior Medical Director (SMD). This includes implementing and overseeing systems and processes to manage, monitor and evaluate the utilization of services members receive through the health delivery network, carrying out work-plan activities, and participating in utilization activities and processes such as, prior authorization reviews, concurrent reviews, case management and retrospective medical claims reviews.

The Manager of Medical Management, under the direction of the SMD, supervises utilization departments and functional areas (Prior Authorization, Utilization Review, Case Management) and is responsible for day-to-day program operations and activities.

The objectives, scope, organization and effectiveness of the Utilization Management Program are evaluated and approved annually by the MQM Committee and the governing board. The annual Utilization Management Program evaluation is submitted to applicable regulatory bodies for approval.

Discharges Per Year

Discharge planning is an important utilization management tool for maintaining continuity of care and preventing readmissions. Concurrent review nurses are responsible for identifying a member's discharge needs during admission/continued stay reviews and assisting hospital staff to make sure that postdischarge care is available and that the member's discharge plan is implemented.

Missouri Care's nurses assist facilities in meeting discharge planning requirements (e.g., by prior authorization of transfers to a lower level of care, coordinating referrals to ancillary services or to case management). Concurrent review nurses work collaboratively with hospital discharge planning staff, members or their caregivers, and physicians to help coordinate the hospital's discharge planning efforts. The team approach results in better continuity of care in the safest and most cost-effective setting and allows hospital and plan personnel to attend more closely to special social, economic, cultural, and language needs that will reinforce improved outcomes for the member.

The following metrics are tracked to identify potential areas of over- or under-utilization of inpatient services:
- Admissions per 1000 members
- Days per 1000 members
- Average Length of stay
- Member outcomes (readmissions, discharge plan evaluation)
- Quality and risk management indicators

Inpatient Visits

Table 4: Inpatient Utilization by Type of Visit (SFY 08)			
Type of Visit	**Admits/1000**	**Days/1000**	**ALOS**
Maternity	70	158	2.2
Newborn	72	128	2.0
NICU	8	85	10.0
High Risk OB	5	27	5.2
Medical/Surgical/ICU	52	143	2.7
Mental Health	13.66	51.72	3.78

Table 5: Inpatient Utilization Trends (SF 06 to SF 08)			
Indicator	SFY 06	SFY 07	SFY 08
Physical Health			
Admits/1000	179	205	213
Days/1000			
• Maternity	129	157	158
• Newborn	101	129	128
• NICU	83	83	85
• High Risk OB	18	29	27
• Medical/Surgical/ICU	151	138	143
Average Length of Stay	3.0	2.8	2.8
Mental Health			
Admits/1000	8.70	7.22	13.66
Days/1000	47.47	39.57	51.72
Average Length of Stay	5.46	5.48	3.78

Re-Admissions
Missouri Care works with health care professionals, providers, members, their families and care givers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources. Missouri Care reports and researches all inpatient readmissions within 30 days of the last admission. The readmission rate for this reporting period was 3.75%. The goal is that less than 10% of members with inpatient admissions readmit within 30 days.

Emergency Department Utilization
Missouri Care understands that members with a medical home are less likely to suffer a costly illness and go to the emergency department for care. When members have a medical home they have an improved quality of care and better outcomes. Missouri Care recognizes members have the right to access emergency health care services when and where the need arises, although many ED visits may be prevented with timely access to primary care. Missouri Care's research identified the following for this reporting period:
   • Top 1% of members account for 12% of total ER utilization (290 members account for 2462
      ER visits in a year)
   • 40% of all ER visits are potentially non emergent
   • Missouri Care ED paid visits/1000 were 917

ER Utilization Project
In October, 2007 Missouri Care launched a pilot project to address ER utilization. The goals for the project were to:
   1. Reduce the number of ER visits by the top 1% of users
   2. Reduce the percentage of potentially inappropriate ER visits, as compared to total
      ER Visits

Interventions included:

1. Individuals with 10 or more ER visits in a year were enrolled in case management and encouraged to have regularly scheduled visits with a PCP
    a. Case managers check in with members once a month
    b. The Senior Medical Director sends a letter to the PCP with a follow up   phone call, as needed (e.g., for members seeking narcotics through the ER)
2. Members with 2 or more inappropriate ER visits within a 6-month period receive a letter & educational flyer on proper ER usage

Initial findings were positive so Missouri   Care is developing an ER PIP in 2009.

Impactable Admissions Project (IAP)
A second ER utilization project is being planned for 2009, focusing on members with co-occurring mental and physical health conditions. The goal for the Impactable Admissions Project (IAP 2) is to reduce ER utilization for the target population by 2.5%.

Interventions for the IAP will focus on:
1. Enrolling members with substance related mental disorder or alcohol related mental disorder and a physical diagnosis in an integrated case management program
2. Providing case management for members with 10 or more ED visits in the past 12 Months

Over/Under Utilization
The Utilization Review and Quality Management Units work in collaboration to develop a tool for screening and reviewing medical documents to identify potential sentinel events as well as quality, utilization, safety, or risk issues in the care or services delivered to members. Indicators for identifying potential over- and underutilization, including target and performance indicators, are listed in Table 6. In SFY 08 Missouri Care documented 4 unplanned transfers or returns to a higher level of care, indicating potential underutilization. There were 32 readmissions to an acute facility within 10 days of diagnosis, and 12 readmissions to a psychiatric facility within 30 days.

Table 6: Summary of Sentinel Events/Quality of Care Issues (SFY 08)	
Unplanned transfer or return to higher level of care (OR/ICU/CCU/NICU/PICU)	4
Readmission to an acute facility within 10 days with same diagnosis	32
Readmission to a psychiatric facility within 30 days	12
FDIU (Fetal Demise Intra-uterine > 20 weeks or > 350 grams)	16
Mortality	5
Neonatal Death of a liveborn neonate before 28 days	2
Surgical misadventure	2
Total Sentinel/Quality of Care Issues	**73**

Sentinel events and quality of care issues are identified during the review of medical documents – during prior authorization, concurrent, retrospective or case management reviews -- or by other departments or activities. All issues are forwarded to the applicable department manager for

investigation and review with the Senior Medical Director, or designee. QOC issues are brought to the attention of the MQM Committee for evaluation and recommended follow-up actions. Issues are tracked in order to identify potential provider or facility trends. Further action may include additional research and review by the Senior Medical Director and/or the MQM Committee.

Inter-Rater Reliability

Missouri Care uses Milliman Care Guidelines for utilization support in making inpatient admission, concurrent review and prior authorization decisions. Missouri Care conducts inter-rater reliability (IRR) assessments annually to evaluate the consistency of decision making and application of criteria in the prior authorization and concurrent review process. Nurses and physicians involved in the prior authorization and concurrent review process are subject to inter-rater reliability assessment. Missouri
Care's goal is each participant in the IRR assessment will obtain a score of 85% or higher on the IRR. In 2007, the overall Missouri Care score was 90%. All areas exceeded the goal of 85%.

Timeliness of Care Delivery Timeliness of Prior Authorization/Certification Decision Making

Missouri Care adheres to the regulatory requirements for the prior authorization of services. The prior authorization process allows Missouri Care to monitor certain outpatient referrals, services and procedures, as well as non-emergency/elective hospitalizations, before the member receives the service or referral.

Prior Authorization

The Prior Authorization and Utilization Review Unit is principally responsible for day-to-day prior authorization operations. Requests are evaluated and documented by licensed nurses. The function is available 24 hours a day, seven days a week and maintains a toll-free telephone number for health professionals and providers.

Prior authorization decisions are made and the health care professional, provider and/or members are notified of decisions within the following time frames:

- Approval or denial of non-emergency services when determined as such by emergency room staff shall be provided by the health plan within thirty (30) minutes of request.

- Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.

- Approval or denial shall be provided within two (2) business days of obtaining all necessary information for routine services. Missouri Care shall notify the requesting provider within two (2) business days following the receipt of the request for service regarding any additional information necessary to make a determination. In no case shall Missouri Care exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial.

- Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized.

Missouri Care monitors prior authorization processes for:
- Timeliness of decisions and notifications to health care professionals and members
- Process performance; telephone abandonment rate, average answer time, timeliness and accuracy of data entry
- Number of authorization requests approved
- Number of authorization requests denied

Concurrent Review
The concurrent review function provides a way to evaluate admissions while a member is hospitalized.
Admissions are reviewed for medical necessity and continuing services are reviewed for the appropriate use of inpatient medical resources. Concurrent review activities identify occurrences of over- or underutilization and physician practice patterns, identify ways to improve members' inpatient care outcomes and monitor the cost effectiveness of the services.

Missouri Care conducts on-site review at the University Missouri Health Center and Columbia Regional Hospital based on high-volume utilization. Daily telephonic reviews are conducted at all other facilities. Services subject to concurrent review are those provided in acute and rehabilitation facilities. Concurrent review nurses working under the direction of the SMD conduct initial reviews of members' admissions within 24 hours of the admission. The concurrent review nurses use nationally recognized criteria in review of inpatient stays. Missouri Care's senior medical director and manager of medical management conduct daily reviews of all inpatient stays and make recommendations as indicated.
Missouri Care makes concurrent review decisions and notifies health care professionals, providers and, if applicable, members within the following time frames, unless otherwise required by the state of Missouri:
- Approval or denial for initial determinations shall be provided by Missouri Care within two (2) working days of obtaining all necessary information.
- Approval or denial for concurrent review determinations shall be provided by Missouri Care within one (1) working day of obtaining all necessary information.
- Approval or denial for retrospective review determinations shall be provided by Missouri Care within thirty (30) working days of receiving all necessary information.
- Missouri Care shall notify the requesting provider within two (2) working days following the receipt of the request of service regarding any additional information necessary to make a determination.
- In no case shall Missouri Care exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.

Molina Healthcare of Missouri

Utilization Improvement Program Scope

The Medical Management Department is organized into five units which report to the Chief Medical Officer. The Preauthorization unit is responsible for prospective review of inpatient, ambulatory medical and pharmacy services to ensure that members receive the most medically appropriate services with a quality provider at the appropriate level of care. The Utilization Review Unit performs concurrent review, retrospective review and discharge planning. The Case Management/Disease Management Unit includes OB Case Managers who are responsible for education of pregnant members, management of high-risk obstetrical patients, outpatient management and monitoring for women in preterm labor. Case management coordinators work in conjunction with the case managers to review requests for durable medical equipment, therapies, Synagis and assist with authorizations. The special needs case managers are responsible for the evaluation and management of complicated medical cases, high-risk social situations and those members with unique medical needs. In the Pharmacy Division, the Director of Pharmacy works closely with the Chief Medical Officer to manage the State-approved formulary and oversee the preauthorization process for medications. In the Quality department, the Director of Quality Improvement provides oversight of the QIP, HEDIS, Credentialing and NCQA accreditation. The Quality department includes a Quality Improvement Analyst who is responsible for assessing quality of care issues and a Quality Improvement Coordinator who is primarily responsible for the credentialing process.

Discharges Per Year

MHMO does not have the ability to track this data at this time.

Inpatient Visits

Inpatient Days/1000 Members	2006	2008	2008 YTD
	391.6	375.6	450.3

Average Length of Stay

MHMO's Average Length of is reflected in the data provided below.

ALOS	1QFY08	2QFY08	3QFY08	4QFY08
Medical/Surgical	2.8	2.8	3.0	3.6
Obstetrics	2.5	2.6	2.66	2.6
Newborn	7.3	5.8	12.9	10.2
Total	12.6	11.2	19.3	16.2

Re-Admissions

MHMO Tracks readmissions that occurred within 7 days from discharge.

Readmissions	1QFY08	2QFY08	3QFY08	4QFY08
	24	22	32	39

Emergency Department Utilization

ER Visits/1000 Members	1QFY08	2QFY08	3QFY08 YTD	4QFY08
	16.3	16.9	19.3	11.5

Outpatient Visits
MHMO does not have the ability to track this data at this time.

Over/Under Utilization
MHMO does not have the ability to track this data at this time.

Inter-Rater Reliability
MHMO is considering conducting inter-rater reliability audits beginning in 2009.

Timeliness of Care Delivery
MHMO does not have the ability to track this data at this time.

Timeliness of Prior Authorization/Certification Decision Making
MHMO does not have the ability to track this data at this time.

This page intentionally left blank.

Performance Improvement Projects (PIP)

The following information contains the titles of each MO HealthNet Managed Care health plan's PIP's. Full text of the individual PIP's can be found in their SFY 2008 Annual Evaluations.

Blue Advantage Plus of Kansas City

Clinical
PIP Title: Improving Ambulatory Follow-Up and Patient Safety

Non-Clinical
PIP Title: Appeals Process Compliance

Children's Mercy Family Health Partners

Clinical
PIP Title: Improving Well Child Visits in the first 15 months of life

Non-Clinical
PIP Title: Improving Non-Emergency Transportation Services

Harmony Health Plan of Missouri

Clinical
PIP Title: Lead Screening Performance Improvement Project
            Adolescent Well Care (State-Wide PIP)
Non-Clinical
PIP Title: Encounter Data Load Process Flow

HealthCare USA

Clinical
PIP Title: Testing for Chlamydia for Women at Risk
            Non-Urgent/Avoidable Emergency Department Utilization
            Beary Important Bundle (BIB) Prenatal Outcomes
            Improving Post-Discharge Management of Members Discharged from an
                Inpatient Service for Mental Illness
            State-Wide Adolescent Well Care
            Obesity
Non-Clinical
PIP Title: Encounter Data Submission
            Appeals and Grievances

Missouri Care

Clinical
PIP Title: Increase Use of Controller Medication for Members with Asthma
            Adolescent Well Care – Statewide PIP
            WIC Partnership to Increase Well Child Checkup Compliance
             Increase Compliance with Chlamydia Screening Recommendations

Non-Clinical
PIP Title: Post-Mental Health Hospitalization Follow-Up within 7 Days of Discharge

Molina Healthcare of Missouri

Clinical
PIP Title: Members at High Risk for Cesarean Wound Infections
          Early Intervention in Prenatal Case Management and the Relationship to Very Low
            birth Weight Babies
Non-Clinical
PIP Title: Pharmacy Process Improvement
          Medication Focus Studies

Work Plan For Next Year (SFY 2009)

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

BA+ 2009 Work Plan: See Attachment 17

Children's Mercy Family Health Partners

CMFHP 2009 Work Plan: See Attachment 18

Harmony Health Plan of Missouri

Harmony 2009 Work Plan: See Attachment 19

HealthCare USA

HealthCare USA 2009 Work Plan: See Attachment 20

Missouri Care

Missouri Care 2009 Work Plan: See Attachment 21

Molina Healthcare of Missouri

Molina 2009 Work Plan: See Attachment 22

This page intentionally left blank.

MARKETING

MO HealthNet Managed Care health plans must submit their proposed marketing plan, all marketing materials and member education materials to the MHD for written approval prior to use. Below are the marketing and education materials submitted for review for SFY2008. Materials were submitted by all health plans as well as for Policy Studies, Inc., Affiliated Computer Services, Inc., Missouri Primary Care Association and Legal Aid of Western Missouri. This report does not include Pharmacy submissions.

Blue –Advantage Plus of Kansas City

Total Marketing Submitted	67
Total Approved	61
Total Denied	01
Total Submitted then Withdrawn	04
Total Other	01

Children's Mercy Family Health Partners

Total Marketing Submitted	254
Total Approved	237
Total Denied	03
Total Submitted then Withdrawn	13
Total Other	01

HealthCare USA

Total Marketing Submitted	183
Total Approved	166
Total Denied	03
Total Submitted then Withdrawn	12
Total Other	02

Harmony Health Plan of Missouri

Total Marketing Submitted	40
Total Approved	32
Total Denied	08
Total Submitted then Withdrawn	00
Total Other	00

Mercy CarePlus

Total Marketing Submitted	123
Total Approved	101
Total Denied	07
Total Submitted then Withdrawn	13
Total Other	02

Missouri Care
Total Marketing Submitted	49
Total Approved	46
Total Denied	00
Total Submitted then Withdrawn	01
Total Other	02

Missouri Primary Care Association
Total Marketing Submitted	04
Total Approved	04
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

Policy Studies, Inc.
Total Marketing Submitted	14
Total Approved	07
Total Denied	07
Total Submitted then Withdrawn	00
Total Other	00

Affiliated Computer Services, Inc.
Total Marketing Submitted	09
Total Approved	09
Total Denied	00
Total Submitted then Withdrawn	00
Other	00

Legal Aid of Western Missouri
Total Marketing Submitted	03
Total Approved	03
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

After review of marketing and education materials by the MHD if changes are needed the health plans are required to correct problems and/or errors as identified by the MHD. MO HealthNet health plans shall return the corrected marketing plan or revised material within ten (10) business days of the receipt date of the written notice from the MHD.

Marketing/Education Materials
MO HealthNet Managed Care health plan marketing and education materials shall include but are not limited to a listing of in-network providers, member's rights and responsibilities, general MO HealthNet Managed Care eligibility information, member education on how to use a health plan and how to assert certain rights with their health plan member benefits, new member orientation, member handbook, and provider directory.

Below is a sampling of marketing and education materials submitted by the MO HealthNet Managed Care health plans in SFY2008. Some of the materials were also submitted in Spanish.

- Member Handbooks/Provider Directory
- Marketing Plan
- Happy Birthday Mailings
- Member Newsletters
- Well Women Mailings
- Member Identification Cards
- Open Enrollment Letters, Flyers, Billboards, Mailers
- Educational Materials/Brochures for asthma, dental, diabetes, ADHD, ADD, smoking cessation, obesity, emergency room usage, lead, prenatal, post-partum, heart health, flu, cancer awareness plus many more.
- Grievance and Appeals Letters
- Pharmacy Lock-In Letters
- Immunizations (Shots)
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Case Management Letters
- Health Plan Website Information
- Community Activities
- Radio Scripts
- TV Ads

MO HealthNet Managed Care health plan marketing and education submissions for SFY2008 totaled 716*.

Although there was a decrease from FY2007 (806) submissions to FY2008 (716) submissions of 11.2% due to the loss of FirstGuard's contract, there remains an increase from FY2006 of (514) submissions to FY2008 of (716) submissions of 39%.

*_Total does not include Missouri Primary Care Association, PSI and Legal Aid of Western Missouri_.

This page intentionally left blank.

MO HealthNet Managed Care
Central Region Annual HEDIS Comparison

Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Adolescent Immunizations	2005	19.21%	30.41%	*	27.55%
	2006	28.01%	40.97%	*	39.83%
	2007	DHSS suspended this measure as it was retired by NCQA			
Adolescent Well-Care Visits	2005	36.19%	44.53%	*	32.68%
	2006	39.06%	44.91%	*	35.68%
	2007	40.19%	49.54%	8.57%	33.41%
Annual Dental Visit Age 2-3	2005	9.65%	9.65%	*	10.82%
	2006	13.72%	10.24%	*	11.61%
	2007	19.60%	11.62%	NA	12.29%
Annual Dental Visit Age 4-7	2005	28.20%	28.85%	*	32.69%
	2006	38.09%	29.77%	*	34.73%
	2007	39.75%	26.75%	NA	31.42%
Annual Dental Visit Age 7-10	2005	32.09%	31.52%	*	37.41%
	2006	40.47%	33.74%	*	40.54%
	2007	42.07%	33.04%	NA	37.49%
Annual Dental Visit Age 11 - 14	2005	29.12%	30.66%	*	32.78%
	2006	34.73%	31.42%	*	34.56%
	2007	38.59%	32.61%	NA	32.14%
Annual Dental Visit Age 15 - 18	2005	21.55%	27.99%	*	27.65%
	2006	30.74%	28.92%	*	29.81%
	2007	30.17%	28.66%	NA	27.02%
Annual Dental Visit Age 19 - 21	2005	8.65%	20.22%	*	16.15%
	2006	16.22%	18.71%	*	18.36%
	2007	10.81%	26.97%	NA	17.16%
Annual Dental Visit Combined Rate	2005	25.05%	26.76%	*	29.34%
	2006	32.73%	27.76%	*	31.45%
	2007	35.08%	27.50%	13.93%	27.54%
Asthma Age 5 - 9	2005	89.22%	83.67%	*	87.94%
	2006	91.07%	90.40%	*	88.72%
	2007	89.41%	88.57%	NA	90.23%
Asthma Age 10 - 19	2005	84.50%	67.76%	*	85.61%
	2006	84.62%	80.16%	*	87.68%
	2007	91.67%	90.48%	NA	87.32%
Asthma Age 18 - 56	2005	84.71%	59.86%	*	75.35%
	2006	76.09%	72.58%	*	78.53%
	2007	67.50%	72.34%	NA	77.11%
Asthma Combined	2005	86.08%	71.09%	*	84.58%
	2006	85.67%	82.75%	*	85.97%
	2007	87.36%	86.96%	NA	87.01%
Cervical Cancer Screening	2005	70.34%	73.32%	*	66.33%
	2006	68.01%	74.59%	*	65.77%
	2007	66.85%	76.35%	NA	56.78%
Childhood Immunization	2005	72.69%	75.18%	*	59.77%
	2006	64.97%	64.81%	*	60.01%
	2007	72.45%	67.92%	NA	55.73%
Chlamydia Screening Age 16 - 20	2005	43.22%	47.03%	*	55.88%
	2006	54.07%	50.64%	*	58.14%
	2007	50.80%	49.86%	NA	51.91%
Chlamydia Screening Age 21 - 26	2005	46.39%	52.28%	*	58.38%
	2006	57.14%	60.69%	*	62.70%
	2007	54.55%	62.06%	NA	60.91%

Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Chlamydia Screening Combined Rate	2005	44.75%	49.44%	*	57.02%
	2006	55.20%	54.24%	*	59.60%
	2007	51.98%	53.76%	NA	55.27%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	1.49%	2.30%	*	2.93%
	2006	0.70%	1.85%	*	3.06%
	2007	1.42%	0.74%	NA	3.76%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	1.86%	0.98%	*	3.63%
	2006	2.51%	2.55%	*	3.63%
	2007	2.13%	0.49%	NA	3.67%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	2.98%	3.93%	*	5.24%
	2006	2.20%	3.01%	*	4.26%
	2007	2.37%	3.92%	NA	5.22%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	5.59%	3.93%	*	7.95%
	2006	4.11%	3.47%	*	7.02%
	2007	3.79%	6.62%	NA	7.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	5.87%	5.25%	*	12.42%
	2006	7.31%	9.49%	*	12.25%
	2007	6.75%	7.11%	NA	11.21%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	13.69%	11.15%	*	18.14%
	2006	10.52%	17.36%	*	18.04%
	2007	12.19%	12.50%	NA	17.19%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	68.53%	72.46%	*	49.69%
	2006	72.65%	62.27%	*	51.74%
	2007	71.36%	68.63%	NA	51.24%
Well Child Visits in the Third through Sixth Year of Life	2005	61.59%	67.37%	*	58.07%
	2006	61.34%	58.97%	*	57.81%
	2007	62.32%	58.22%	42.55%	53.69%
Timeliness of Prenatal Care	2005	53.82%	89.05%	*	56.28%
	2006	92.07%	93.24%	*	79.88%
	2007	91.40%	91.11%	NA	77.95%
Postpartum Care	2005	51.11%	66.91%	*	50.15%
	2006	69.00%	71.56%	*	61.69%
	2007	72.79%	70.83%	NA	58.68%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	34.69%	17.65%	*	31.46%
	2006	29.53%	42.58%	*	36.99%
	2007	42.65%	30.00%	NA	36.52%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	60.54%	47.79%	*	55.92%
	2006	56.38%	63.16%	*	61.85%
	2007	71.32%	67.78%	NA	64.50%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Eastern Region Annual HEDIS Comparison

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Adolescent Immunizations	2005	*	43.52%	24.57%	25.79%	27.55%
	2006	*	57.64%	**	72.51%	39.83%
	2007	DHSS suspended this measure as it was retired by NCQA				
Adolescent Well-Care Visits	2005	*	35.55%	30.90%	28.92%	32.68%
	2006	*	36.49%	**	29.49%	35.68%
	2007	25.06%	40.35%	**	43.55%	33.41%
Annual Dental Visit Age 2-3	2005	*	10.00%	7.83%	9.04%	10.82%
	2006	*	11.23%	**	9.12%	11.61%
	2007	3.69%	12.40%	**	9.01%	12.29%
Annual Dental Visit Age 4-7	2005	*	34.78%	29.77%	31.73%	32.69%
	2006	*	37.19%	**	33.64%	34.73%
	2007	19.93%	39.42%	**	33.76%	31.42%
Annual Dental Visit Age 7-10	2005	*	37.96%	36.73%	38.14%	37.41%
	2006	*	42.19%	**	40.59%	40.54%
	2007	25.93%	46.04%	**	41.74%	37.49%
Annual Dental Visit Age 11 - 14	2005	*	32.32%	32.22%	32.34%	32.78%
	2006	*	35.44%	**	34.07%	34.56%
	2007	16.55%	35.97%	**	37.41%	32.14%
Annual Dental Visit Age 15 - 18	2005	*	26.34%	27.41%	26.62%	27.65%
	2006	*	27.92%	**	27.18%	29.81%
	2007	16.67%	29.25%	**	28.44%	27.02%
Annual Dental Visit Age 19 - 21	2005	*	17.18%	17.60%	18.45%	16.15%
	2006	*	19.30%	**	20.00%	18.36%
	2007	9.41%	16.82%	**	15.11%	17.16%
Annual Dental Visit Combined Rate	2005	*	29.81%	27.71%	29.08%	29.34%
	2006	*	32.52%	**	30.45%	31.45%
	2007	16.94%	34.61%	**	30.75%	27.54%
Asthma Age 5 - 9	2005	*	88.46%	88.12%	79.31%	87.94%
	2006	*	86.29%	**	86.02%	88.72%
	2007	NA	87.75%	**	85.07%	90.23%
Asthma Age 10 - 19	2005	*	85.79%	87.62%	83.94%	85.61%
	2006	*	87.51%	**	89.84%	87.68%
	2007	NA	86.88%	**	84.51%	87.32%
Asthma Age 18 - 56	2005	*	77.52%	84.48%	66.24%	75.35%
	2006	*	82.28%	**	71.60%	78.53%
	2007	NA	83.46%	**	80.95%	77.11%
Asthma Combined	2005	*	85.51%	87.12%	78.08%	84.58%
	2006	*	86.43%	**	85.66%	85.97%
	2007	NA	86.87%	**	84.16%	87.01%
Cervical Cancer Screening	2005	*	71.43%	65.94%	59.53%	66.33%
	2006	*	70.79%	**	61.25%	65.77%
	2007	40.20%	68.36%	**	46.57%	56.78%
Childhood Immunization	2005	*	62.65%	43.07%	61.31%	59.77%
	2006	*	55.79%	**	52.55%	60.01%
	2007	27.27%	57.41%	**	54.01%	55.73%
Chlamydia Screening Age 16 - 20	2005	*	61.07%	50.91%	83.19%	55.88%
	2006	*	67.52%	**	63.33%	58.14%
	2007	57.28%	62.68%	**	47.86%	51.91%
Chlamydia Screening Age 21 - 26	2005	*	64.42%	51.42%	88.67%	58.38%
	2006	*	71.32%	**	65.22%	62.70%
	2007	57.43%	70.65%	**	52.71%	60.91%

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Chlamydia Screening Combined Rate	2005	*	62.70%	51.17%	85.67%	57.02%
	2006	*	69.14%	**	64.09%	59.60%
	2007	57.35%	65.81%	**	49.80%	55.27%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	*	2.77%	2.43%	3.09%	2.93%
	2006	*	4.63%	**	6.93%	3.06%
	2007	11.63%	5.13%	**	4.38%	3.76%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	*	3.42%	1.46%	4.26%	3.63%
	2006	*	3.14%	**	4.52%	3.63%
	2007	8.14%	3.63%	**	7.79%	3.67%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	*	6.27%	4.14%	5.78%	5.24%
	2006	*	5.11%	**	5.37%	4.26%
	2007	2.33%	5.13%	**	10.95%	5.22%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	*	9.28%	6.57%	8.73%	7.95%
	2006	*	8.59%	**	9.82%	7.02%
	2007	9.30%	8.90%	**	11.68%	7.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	*	15.74%	11.44%	14.24%	12.42%
	2006	*	14.14%	**	14.77%	12.25%
	2007	10.47%	13.37%	**	14.60%	11.21%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	*	21.76%	15.57%	18.84%	18.14%
	2006	*	20.63%	**	19.86%	18.04%
	2007	16.28%	20.94%	**	18.25%	17.19%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	*	40.76%	58.39%	45.05%	49.69%
	2006	*	43.76%	**	38.73%	51.74%
	2007	41.86%	42.90%	**	32.36%	51.24%
Well Child Visits in the Third through Sixth Year of Life	2005	*	58.84%	52.07%	55.81%	58.07%
	2006	*	59.78%	**	52.83%	57.81%
	2007	48.18%	62.27%	**	50.94%	53.69%
Timeliness of Prenatal Care	2005	*	52.66%	41.12%	64.72%	56.28%
	2006	*	80.09%	**	83.94%	79.88%
	2007	86.51%	83.53%	**	78.35%	77.95%
Postpartum Care	2005	*	37.00%	53.77%	52.07%	50.15%
	2006	*	52.78%	**	59.85%	61.69%
	2007	55.56%	54.76%	**	54.74%	58.68%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	*	28.28%	25.78%	25.26%	31.46%
	2006	*	26.75%	**	24.68%	36.99%
	2007	NA	30.59%	**	31.05%	36.52%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	*	49.25%	51.27%	49.12%	55.92%
	2006	*	48.89%	**	46.31%	61.85%
	2007	NA	57.45%	**	52.62%	64.50%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Western Region Annual HEDIS Comparison

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Adolescent Immunizations	2005	0.00%	68.86%	17.03%	18.59%	**	27.55%
	2006	16.79%	36.50%	*	26.42%	**	39.83%
	2007	DHSS suspended this measure as it was retired by NCQA					
Adolescent Well-Care Visits	2005	32.65%	33.09%	28.64%	23.67%	**	32.68%
	2006	32.65%	42.82%	*	24.35%	**	35.68%
	2007	34.79%	41.61%	*	32.56%	17.83%	33.41%
Annual Dental Visit Age 2-3	2005	13.37%	15.84%	13.03%	8.98%	**	10.82%
	2006	12.23%	15.80%	*	8.94%	**	11.61%
	2007	11.24%	15.01%	*	11.39%	16.67%	12.29%
Annual Dental Visit Age 4-7	2005	36.12%	41.34%	36.31%	27.11%	**	32.69%
	2006	36.95%	40.66%	*	26.82%	**	34.73%
	2007	33.46%	41.43%	*	34.20%	14.08%	31.42%
Annual Dental Visit Age 7-10	2005	41.27%	45.37%	41.91%	31.73%	**	37.41%
	2006	44.52%	46.85%	*	35.40%	**	40.54%
	2007	42.60%	48.87%	*	38.00%	19.10%	37.49%
Annual Dental Visit Age 11 - 14	2005	36.24%	40.85%	35.91%	25.37%	**	32.78%
	2006	36.94%	40.95%	*	28.36%	**	34.56%
	2007	37.64%	42.62%	*	34.07%	13.83%	32.14%
Annual Dental Visit Age 15 - 18	2005	31.64%	34.79%	32.34%	20.14%	**	27.65%
	2006	31.33%	34.30%	*	28.31%	**	29.81%
	2007	30.95%	34.93%	*	29.85%	14.29%	27.02%
Annual Dental Visit Age 19 - 21	2005	15.32%	16.60%	15.88%	15.45%	**	16.15%
	2006	17.38%	25.19%	*	11.70%	**	18.36%
	2007	16.89%	26.27%	*	15.02%	NA	17.16%
Annual Dental Visit Combined Rate	2005	32.82%	37.07%	32.60%	23.19%	**	29.34%
	2006	33.72%	37.49%	*	25.46%	**	31.45%
	2007	32.54%	38.59%	*	30.29%	15.16%	27.54%
Asthma Age 5 - 9	2005	93.48%	92.83%	88.41%	NA	**	87.94%
	2006	91.88%	90.06%	*	NA	**	88.72%
	2007	93.57%	92.38%	*	94.87%	NA	90.23%
Asthma Age 10 - 19	2005	87.50%	91.91%	95.83%	NA	**	85.61%
	2006	91.36%	92.58%	*	NA	**	87.68%
	2007	86.14%	90.29%	*	81.25%	NA	87.32%
Asthma Age 18 - 56	2005	74.23%	70.48%	85.29%	NA	**	75.35%
	2006	83.33%	85.32%	*	NA	**	78.53%
	2007	80.00%	78.41%	*	NA	NA	77.11%
Asthma Combined	2005	87.12%	89.34%	90.07%	86.79%	**	84.58%
	2006	90.43%	90.57%	*	80.28%	**	85.97%
	2007	88.63%	89.73%	*	85.37%	NA	87.01%
Cervical Cancer Screening	2005	66.39%	66.69%	67.40%	55.96%	**	66.33%
	2006	68.23%	63.78%	*	53.74%	**	65.77%
	2007	65.21%	66.84%	*	55.22%	25.45%	56.78%
Childhood Immunization	2005	47.65%	66.00%	49.64%	59.79%	**	59.77%
	2006	60.83%	67.15%	*	53.94%	**	60.01%
	2007	54.43%	56.79%	*	55.56%	NA	55.73%
Chlamydia Screening Age 16 - 20	2005	42.54%	58.46%	60.63%	55.84%	**	55.88%
	2006	49.14%	55.82%	*	66.47%	**	58.14%
	2007	41.95%	50.06%	*	54.81%	NA	51.91%
Chlamydia Screening Age 21 - 26	2005	46.38%	60.22%	62.76%	52.86%	**	58.38%
	2006	65.00%	66.67%	*	52.88%	**	62.70%
	2007	64.80%	61.32%	*	63.77%	NA	60.91%

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Chlamydia Screening Combined Rate	2005	44.43%	59.23%	61.75%	54.07%	**	57.02%
	2006	55.79%	59.54%	*	59.22%	**	59.60%
	2007	50.52%	53.80%	*	59.10%	NA	55.27%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	2.78%	2.80%	3.89%	4.82%	**	2.93%
	2006	2.78%	1.74%	*	2.79%	**	3.06%
	2007	2.69%	2.06%	*	2.08%	NA	3.76%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	4.63%	4.34%	4.62%	7.11%	**	3.63%
	2006	4.63%	2.73%	*	5.35%	**	3.63%
	2007	4.30%	1.03%	*	1.85%	NA	3.67%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	5.86%	6.68%	4.14%	7.34%	**	5.24%
	2006	5.86%	2.23%	*	6.05%	**	4.26%
	2007	6.09%	3.61%	*	7.41%	NA	5.22%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	8.79%	9.14%	9.00%	10.55%	**	7.95%
	2006	8.79%	6.20%	*	8.14%	**	7.02%
	2007	9.13%	3.35%	*	8.80%	NA	7.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	15.57%	16.50%	9.49%	17.66%	**	12.42%
	2006	15.57%	8.44%	*	16.05%	**	12.25%
	2007	14.68%	9.54%	*	13.19%	NA	11.21%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	23.36%	25.81%	12.65%	20.41%	**	18.14%
	2006	23.36%	16.63%	*	17.91%	**	18.04%
	2007	23.10%	13.66%	*	20.60%	NA	17.19%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	39.01%	34.72%	56.20%	32.11%	**	49.69%
	2006	39.01%	62.03%	*	43.72%	**	51.74%
	2007	40.02%	66.75%	*	46.06%	NA	51.24%
Well Child Visits in the Third through Sixth Year of Life	2005	55.70%	72.75%	50.99%	47.50%	**	58.07%
	2006	55.70%	66.27%	*	49.79%	**	57.81%
	2007	55.43%	62.53%	*	60.42%	34.04%	53.69%
Timeliness of Prenatal Care	2005	39.96%	75.43%	49.15%	40.58%	**	56.28%
	2006	39.54%	79.51%	*	90.74%	**	79.88%
	2007	43.87%	80.89%	*	86.11%	59.78%	77.95%
Postpartum Care	2005	56.05%	56.69%	43.31%	34.42%	**	50.15%
	2006	56.34%	57.28%	*	65.05%	**	61.69%
	2007	54.88%	52.11%	*	61.34%	51.09%	58.68%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	50.17%	45.15%	35.34%	20.83%	**	31.46%
	2006	58.67%	48.51%	*	28.21%	**	36.99%
	2007	51.39%	34.42%	*	35.53%	NA	36.52%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	72.76%	71.52%	59.40%	41.67%	**	55.92%
	2006	76.00%	88.37%	*	53.85%	**	61.85%
	2007	75.00%	69.85%	*	57.51%	NA	64.50%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Central Region Annual CAHPS Comparison

Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Getting Needed Care (% Not a Problem)	2005	78.95%	79.35%		80.16%
	2006	81.60%	81.36%		80.07%
	2007	80.82%	80.09%		77.38%
Getting Care Quickly (% Always/Usually)	2005	82.59%	76.74%		79.02%
	2006	82.61%	81.27%		79.42%
	2007	83.85%	81.37%		77.19%
Courteous and Helpful Staff (% Always/Usually)	2005	92.91%	94.88%		92.00%
	2006	93.71%	92.00%		91.38%
	2007	93.99%	92.49%		91.09%
How Well Doctors Communicate (% Always/Usually)	2005	93.20%	90.94%		91.24%
	2006	91.77%	91.90%		90.45%
	2007	92.69%	91.67%		90.04%
Customer Service (% Not a Problem)	2005	70.92%	70.95%		74.86%
	2006	69.89%	79.34%		73.46%
	2007	80.88%	69.46%		71.78%
Rating of Doctor (% 8, 9, 10)	2005	80.83%	76.69%		80.23%
	2006	81.15%	78.44%		79.40%
	2007	83.27%	79.89%		80.12%
Rating of Specialist (% 8, 9, 10)	2005	77.42%	69.23%		76.79%
	2006	80.67%	76.36%		75.46%
	2007	75.21%	76.09%		79.82%
Rating of Health Care (% 8, 9, 10)	2005	82.75%	78.31%		80.92%
	2006	83.71%	79.58%		78.81%
	2007	83.22%	77.65%		79.07%
Rating of Plan (% 8, 9, 10)	2005	79.30%	73.13%		79.94%
	2006	80.61%	77.51%		79.96%
	2007	83.63%	75.47%		77.59%

MO HealthNet Managed Care
Eastern Region Annual CAHPS Comparison

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Getting Needed Care **(% Not a Problem)**	2005		80.17%	79.86%	80.09%	80.16%
	2006		78.69%		81.11%	80.07%
	2007	67.47%	81.56%		79.70%	77.38%
Getting Care Quickly **(% Always/Usually)**	2005		78.40%	83.52%	75.03%	79.02%
	2006		78.56%		81.00%	79.42%
	2007	68.88%	76.99%		77.66%	77.19%
Courteous and Helpful Staff **(% Always/Usually)**	2005		91.30%	93.68%	90.93%	92.00%
	2006		89.72%		91.13%	91.38%
	2007	85.10%	92.45%		91.98%	91.09%
How Well Doctors Communicate **(% Always/Usually)**	2005		91.37%	92.68%	89.69%	91.24%
	2006		89.07%		90.54%	90.45%
	2007	86.14%	90.62%		90.03%	90.04%
Customer Service **(% Not a Problem)**	2005		77.45%	74.97%	72.12%	74.86%
	2006		75.64%		72.75%	73.46%
	2007	61.14%	77.59%		75.46%	71.78%
Rating of Doctor **(% 8, 9, 10)**	2005		83.53%	85.05%	81.23%	80.23%
	2006		78.67%		81.38%	79.40%
	2007	72.97%	84.16%		84.52%	80.12%
Rating of Specialist **(% 8, 9, 10)**	2005		78.45%	75.45%	82.43%	76.79%
	2006		70.69%		73.40%	75.46%
	2007	75.86%	84.11%		88.16%	79.82%
Rating of Health Care **(% 8, 9, 10)**	2005		85.58%	84.51%	81.76%	80.92%
	2006		79.51%		82.00%	78.81%
	2007	67.59%	81.87%		80.78%	79.07%
Rating of Plan **(% 8, 9, 10)**	2005		85.52%	83.37%	79.32%	79.94%
	2006		81.54%		78.03%	79.96%
	2007	71.22%	83.51%		78.48%	77.59%

406

MO HealthNet Managed Care
Western Region Annual CAHPS Comparison

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans
Getting Needed Care (% Not a Problem)	2005	81.34%	82.01%	80.49%	79.17%		80.16%
	2006	80.07%	83.24%		73.38%		80.07%
	2007	81.61%	80.15%		80.42%	64.61%	77.38%
Getting Care Quickly (% Always/Usually)	2005	79.50%	80.38%	78.88%	76.14%		79.02%
	2006	77.74%	78.01%		75.14%		79.42%
	2007	79.43%	80.87%		77.81%	67.88%	77.19%
Courteous and Helpful Staff (% Always/Usually)	2005	92.18%	90.54%	91.24%	90.35%		92.00%
	2006	89.90%	95.55%		87.93%		91.38%
	2007	90.50%	91.88%		90.38%	91.06%	91.09%
How Well Doctors Communicate (% Always/Usually)	2005	91.98%	92.73%	90.98%	87.61%		91.24%
	2006	88.95%	93.93%		86.91%		90.45%
	2007	89.84%	91.88%		92.65%	84.89%	90.04%
Customer Service (% Not a Problem)	2005	77.02%	80.37%	78.78%	71.20%		74.86%
	2006	63.97%	86.09%		67.22%		73.46%
	2007	73.69%	74.04%		73.94%	59.83%	71.78%
Rating of Doctor (% 8, 9, 10)	2005	78.27%	82.22%	78.59%	75.69%		80.23%
	2006	79.24%	81.19%		73.72%		79.40%
	2007	82.50%	84.50%		77.65%	71.67%	80.12%
Rating of Specialist (% 8, 9, 10)	2005	76.54%	82.93%	70.24%	78.38%		76.79%
	2006	79.38%	79.03%		70.73%		75.46%
	2007	80.68%	80.88%		80.49%	76.92%	79.82%
Rating of Health Care (% 8, 9, 10)	2005	79.83%	83.50%	78.35%	73.65%		80.92%
	2006	82.37%	69.31%		72.00%		78.81%
	2007	83.48%	84.13%		83.02%	69.86%	79.07%
Rating of Plan (% 8, 9, 10)	2005	81.21%	82.20%	78.77%	76.63%		79.94%
	2006	81.95%	83.46%		78.52%		79.96%
	2007	79.63%	84.55%		78.90%	62.89%	77.59%

This page intentionally left blank.

MO HealthNet Managed Care
2008 Dentist/Enrollee Ratios

EAST	Dentists	Enrollees	Dentist/Enrollee Ratio
Harmony	148	10,294	1 / 70
Healthcare USA(1)	198	117,951	1 / 596
Mercy CarePlus(2)	204	64,277	1 / 315

(1) **Healthcare USA** submitted one network that covers all three regions. For Healthcare USA, the East Dentist count contains dental providers located within the East region service area.

(2) **Mercy CarePlus** submitted one network that covers all three regions. For Mercy CarePlus, the East Dentist count contains dental providers located within the East region service area, plus two (2) providers located in Cape Girardeau, MO and one (1) provider located in Marble Hill, MO.

CENTRAL	Dentists	Enrollees	Dentist/Enrollee Ratio
Healthcare USA(3)	36	26,061	1 / 724
Mercy CarePlus(4)	30	5,764	1 / 192
Missouri Care	55	40,413	1 / 735

(3) **Healthcare USA** submitted one network that covers all three regions. For Healthcare USA, the Central Dentist count contains dental providers located within the Central region service area, plus five (5) providers located in Licking, MO.

(4) **Mercy CarePlus** submitted one network that covers all three regions. For Mercy CarePlus, the Central Dentist count contains dental providers located within the Central region service area, plus four (4) providers located in Chillicothe, MO and three (3) providers located in Kirksville, MO.

WEST	Dentists	Enrollees	Dentist/Enrollee Ratio
Blue Advantage Plus	116	27,557	1 / 238
Childrens Mercy Family Health Partners	196	48,284	1 / 246
Healthcare USA(5)	101	37,280	1 / 369
Mercy CarePlus(6)	141	7,675	1 / 54

(5) **Healthcare USA** submitted one network that covers all three regions. For Healthcare USA, the West Dentist count contains dental providers located within the West region service area, plus twelve (12) providers located in Springfield, MO and three (3) providers located in the Kansas City, KS area.

(6) **Mercy CarePlus** submitted one network that covers all three regions. For Mercy CarePlus, the West Dentist count contains dental providers located within the West region service area, plus sixteen (16) providers located in the Kansas City, KS area and ten (10) providers located in Springfield, MO.

SOURCES:

Dentists: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). (Provider networks as of January 1, 2008)

Enrollees: January 28, 2008 enrollment data from MHD's Managed Care Operations Unit.

One state (New Jersey) requires a dentist/enrollee ratio of no greater than 1/1500.
Five states (Maryland, New York, Oklahoma, Rhode Island, Virginia) require a dentist/enrollee ratio of no greater than 1/2000.
Source:
http://www.gwumc.edu/sphhs/healthpolicy/nnhs4/GSA/Subheads/gsa140.html

MO HealthNet Managed Care
2008 Mental Health Provider/Enrollee Ratios

EAST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Harmony	264	10,294	1 / 39
Healthcare USA(1)	1,081	117,951	1 / 109
Mercy CarePlus(2)	187	64,277	1 / 344

(1) **Healthcare USA** submitted one network that included all three regions. For Healthcare USA, East region provider count contains MH providers located within the East region service area.

(2) **Mercy CarePlus** submitted one network that included all three regions. For Mercy CarePlus, East region provider count contains MH providers located within the East region service area.

CENTRAL	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Healthcare USA(3)	202	26,061	1 / 129
Mercy CarePlus(4)	334	5,764	1 / 17
Missouri Care	415	40,413	1 / 97

(3) **Healthcare USA** submitted one network that included all three regions. For Healthcare USA, Central region provider count contains MH providers located within the Central region service area, plus eighteen (18) providers in Windsor, MO.

(4) **Mercy CarePlus** submitted one network that included all three regions. For Mercy CarePlus, Central region provider count contains MH providers located within the Central region service area, plus seven (7) providers in Warsaw, MO and eighteen (18) providers in Windsor, MO.

WEST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Blue Advantage Plus	2,567	27,557	1 / 11
Childrens Mercy Family Health Partners	858	48,284	1 / 56
Healthcare USA(5)	308	37,280	1 / 121
Mercy CarePlus(6)	575	7,675	1 / 13

(5) **Healthcare USA** submitted one network that included all three regions. For Healthcare USA, West region provider count contains MH providers located within the West region service area.

(6) **Mercy CarePlus** submitted one network that included all three regions. For Mercy CarePlus, West region provider count contains MH providers located within the West region service area, plus seven (7) providers in Warsaw, MO.

SOURCES:

MH Providers: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).
Includes Adult/General Psychiatrists, Child/Adolescent Psychiatrists, and Psychologists/Other.
(Provider networks as of January 1, 2008)

Enrollees: January 28, 2008 enrollment data from MHD's Managed Care Operations Unit.

MO HealthNet Managed Care
2008 PCP/Enrollee Ratios

EAST	PCPs	Enrollees	PCP/Enrollee Ratio
Harmony	611	10,294	1 / 17
Healthcare USA(1)	931	117,951	1 / 127
Mercy CarePlus(2)	921	64,277	1 / 70

(1) **Healthcare USA** submitted one network covering all three regions. For Healthcare USA, four (4) providers in Cuba, MO are included in the PCP count for the East and Central regions.

(2) **Mercy CarePlus** submitted one network covering all three regions. For Mercy CarePlus, one (1) provider in Cuba, MO is included in the PCP count for the East and Central regions.

CENTRAL	PCPs	Enrollees	PCP/Enrollee Ratio
Healthcare USA(3)	506	26,061	1 / 52
Mercy CarePlus(4)	451	5,764	1 / 13
Missouri Care	789	40,413	1 / 51

(3) For **Healthcare USA**, four (4) providers in Cuba, MO are included in the PCP count for the East and Central regions; three (3) providers in Hermitage, MO are included in the PCP count for the Central and West regions; eleven (11) providers in Warsaw, MO are included in the PCP count for the Central and West regions; and one (1) provider in Windsor, MO is included in the PCP count for the Central and West regions.

(4) For **Mercy CarePlus**, one (1) provider in Cuba, MO is included in the PCP count for the East and Central regions. Five (5) providers in Hermitage MO, eighteen (18) providers in Warsaw MO, three (3) providers in Wheatland MO, and four (4) providers in Windsor MO are included in the PCP count for the Central and West regions.

WEST	PCPs	Enrollees	PCP/Enrollee Ratio
Blue Advantage Plus	455	27,557	1 / 61
Childrens Mercy Family Health Partners	585	48,284	1 / 83
Healthcare USA(5)	760	37,280	1 / 49
Mercy CarePlus(6)	605	7,675	1 / 13

(5) For **Healthcare USA**, three (3) providers in Hermitage, MO are included in the PCP count for the Central and West regions, eleven (11) providers in Warsaw, MO are included in the PCP count for the Central and West regions; and one (1) provider in Windsor, MO is included in the PCP count for the Central and West regions.

(6) For **Mercy CarePlus:**
Five (5) providers in Hermitage MO, eighteen (18) providers in Warsaw MO, three (3) providers in Wheatland MO, and four (4) providers in Windsor MO are included in the PCP count for the Central and West regions.

SOURCES:

PCPs: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP). (Provider networks as of January 1, 2008)

Enrollees: January 28, 2008 enrollment data from MHD's Managed Care Operations Unit

NOTE: PCP/Enrollee ratios in the range of 1/1500 to 1/2500 have been used to represent adequate staffing levels both in federal health programs, and in individual states: http://www.gencmh.org/documents/42CFR.pdf

This page intentionally left blank

MO HealthNet Managed Care
2008 Average Distance to PCP   (as calculated by GeoNetworks™)

Central Region

County	MC+ Eligibles	Distance Standard (for PCP)	Healthcare USA - Central		Mercy CarePlus - Central		Missouri Care	
			PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)
Audrain	2,837	30 miles	29	2.6	26	2.8	23	2.6
Benton	2,133	30 miles	14	5.3	20	5.5	4	5.5
Boone	10,621	20 miles	47	3.1	24	4.3	163	2.3
Callaway	3,378	30 miles	15	4.2	11	5.1	21	4.0
Camden	3,395	30 miles	22	3.4	14	4.0	22	3.2
Chariton	802	30 miles	13	2.9	16	2.4	8	2.4
Cole	5,333	20 miles	49	3.2	45	3.3	36	3.3
Cooper	1,330	30 miles	3	4.5	10	4.9	11	5.9
Gasconade	1,226	30 miles	15	3.2	11	3.6	12	3.9
Howard	1,071	30 miles	1	6.3	0	12.0	10	4.9
Laclede	4,502	30 miles	23	4.9	33	5.4	27	6.0
Linn	978	30 miles	7	4.5	1	4.7	9	5.1
Macon	1,381	30 miles	10	6.3	7	6.4	5	7.4
Maries	733	30 miles	7	3.9	8	4.5	1	8.4
Marion	3,532	30 miles	19	4.3	22	2.7	0	17.9
Miller	3,146	30 miles	25	3.4	19	3.5	14	4.7
Moniteau	1,092	30 miles	4	9.3	4	4.1	4	4.9
Monroe	383	30 miles	1	6.4	2	6.6	3	6.4
Montgomery	1,226	30 miles	10	5.0	12	5.0	6	5.4
Morgan	2,441	30 miles	12	5.1	7	5.1	8	6.1
Osage	575	30 miles	12	4.3	13	4.3	1	6.1
Pettis	4,943	30 miles	20	2.4	8	2.8	22	2.6
Phelps	4,520	30 miles	30	3.2	27	3.6	32	3.4
Pulaski	3,566	30 miles	22	3.3	21	3.7	18	4.8
Ralls	824	30 miles	5	3.7	8	3.3	5	8.7
Randolph	2,726	30 miles	25	2.8	2	3.1	15	2.4
Saline	2,403	30 miles	12	3.0	7	3.0	19	3.0
Shelby	640	30 miles	2	4.8	3	5.5	2	4.8
Totals:	71,737		454		381		501	

413

MO HealthNet Managed Care
2008 Average Distance to PCP   (as calculated by GeoNetworks™)

Eastern Region

County	MC+ Eligibles	Distance Standard (for PCP)	Harmony Health Plan		Healthcare USA - East		Mercy CarePlus - East	
			PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)
Franklin	6,742	20 miles	4	6.8	67	3.9	34	4.0
Jefferson	12,624	20 miles	11	3.1	23	2.6	35	2.3
Lincoln	4,386	30 miles	8	5.3	15	4.1	17	5.4
Madison	1,597	30 miles	1	5.1	n/a*	n/a*	16	4.8
Perry	1,458	30 miles	5	4.6	n/a*	n/a*	14	4.7
Pike	1,478	30 miles	5	3.5	16	2.7	20	3.5
St. Charles	11,772	10 miles	25	2.2	81	1.6	70	1.7
St. Francois	6,983	20 miles	9	4.1	48	2.8	45	2.8
St. Louis	74,571	10 miles	201	1.3	341	0.9	321	1.0
St. Louis city	60,340	10 miles	292	0.5	281	0.5	283	0.5
Ste. Genevieve	1,304	30 miles	12	4.8	10	4.8	13	4.8
Warren	2,686	30 miles	2	4.8	23	4.1	9	4.7
Washington	3,752	30 miles	24	5.0	20	5.3	19	5.0

Totals: 189,693   599   925   896

* Healthcare USA was not under contract to provide services to Madison or Perry counties in 2008.

MO HealthNet Managed Care
2008 Average Distance to PCP   (as calculated by GeoNetworks™)

Western Region

County	MC+ Eligibles	Distance Standard (for PCP)	Blue Advantage Plus		Childrens Mercy Family Health Partners		Healthcare USA - West		Mercy CarePlus - West	
			PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)	PCPs	Average distance to PCP (miles)
Bates	1,453	30 miles	n/a*	n/a*	7	3.7	7	3.7	14	1.6
Cass	6,959	20 miles	22	2.8	15	3.0	24	2.7	22	2.9
Cedar	2,063	30 miles	n/a*	n/a*	5	3.5	12	3.4	12	3.5
Clay	12,649	20 miles	28	2.5	44	1.6	31	2.0	1	5.1
Henry	2,319	30 miles	14	3.2	15	3.2	24	3.1	24	3.6
Jackson	76,010	10 miles	234	1.5	293	1.4	278	1.5	165	1.5
Johnson	3,330	30 miles	13	3.8	12	4.0	19	3.8	19	4.0
Lafayette	2,962	30 miles	27	3.0	42	3.0	68	3.0	49	2.8
Platte	3,381	20 miles	16	2.3	23	2.0	24	2.3	14	4.0
Polk	3,552	30 miles	n/a*	n/a*	19	2.7	22	3.0	29	2.6
Ray	1,616	30 miles	7	4.1	6	4.1	2	4.8	3	7.2
St. Clair	985	30 miles	7	5.7	14	4.9	14	4.7	17	4.9
Vernon	2,400	30 miles	n/a*	n/a*	6	4.2	11	4.1	17	2.8
Totals:	119,679		368		501		536		386	

*Blue Advantage Plus was not under contract to provide services to Bates, Cedar, Polk, and Vernon counties in 2008.

This page intentionally left blank.

MO HealthNet Managed Care
GeoAccess Summary - 2008

	Ancillary	Facilities	PCPs	Specialists	Overall Network Score
Blue Advantage Plus	97%	99%	100%	100%	**99%**
Childrens Mercy Family Health Partners	97%	98%	100%	99%	**98%**
Harmony Health Plan	94%	98%	100%	99%	**98%**
Healthcare USA - Central region	93%	98%	100%	100%	**98%**
Healthcare USA - Eastern region	100%	100%	100%	100%	**100%**
Healthcare USA - Western Region	75%	94%	100%	99%	**92%**
Mercy CarePlus - Central region	87%	89%	100%	98%	**93%**
Mercy CarePlus - Eastern region	100%	100%	100%	98%	**100%**
Mercy CarePlus - Western region	99%	87%	100%	100%	**96%**
Missouri Care	91%	97%	100%	100%	**97%**

Childrens Mercy Family Health Partners

Cedar County:
- Dermatology (88%)
- Infectious Disease (88%)
- Neonatal Intensive Care Unit (88%)
- Perinatology Services (88%)

Polk County:
- Dermatology (12%)
- Gastroenterology (18%)
- Infectious Disease (12%)
- Neonatal Intensive Care Unit (12%)
- Nephrology (18%)
- Occupational Therapy (19%)
- Perinatology Services (12%)
- Physical Medicine/Rehab (19%)

Vernon County:
- Audiology (25%)

Mercy CarePlus - Western Region

Bates County:
- Ambulatory Mental Health Treatment Facilities (45%)
- Pediatric Subspecialty Care (76%)

Cass County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (2%)

Cedar County:
- Ambulatory Mental Health Treatment Facilities (0%)

Clay County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (0%)

Henry County:
- Ambulatory Mental Health Treatment Facilities (9%)

Jackson County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (0%)

Johnson County:
- Pediatric Subspecialty Care (4%)

Lafayette County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (65%)

Platte County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (0%)

Polk County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Physical Therapy (48%)

Ray County:
- Pediatric Subspecialty Care (0%)
- Perinatology Services (0%)

St. Clair County:
- Ambulatory Mental Health Treatment Facilities (0%)

Vernon County:
- Ambulatory Mental Health Treatment Facilities (0%)

Healthcare USA - Western Region

Bates County:
- Ambulatory Mental Health Treatment Facilities (53%)
- Audiology (24%)
- Occupational Therapy (74%)
- Physical Therapy (74%)

Cass County:
- Psychologists/Other Therapy (85%)

Cedar County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Audiology (37%)
- Inpatient Mental Health Treatment Facilities (0%)
- Occupational Therapy (2%)
- Physical Therapy (2%)
- Psychologists/Other Therapy (52%)
- Speech Therapy (46%)

Henry County:
- Ambulatory Mental Health Treatment Facilities (9%)
- Audiology (28%)
- Occupational Therapy (85%)
- Physical Therapy (85%)

Platte County:
- Psychologists/Other Therapy (85%)

Polk County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Inpatient Mental Health Treatment Facilities (0%)
- Occupational Therapy (80%)
- Physical Therapy (80%)
- Psychologists/Other Therapy (5%)

Ray County:
- Occupational Therapy (86%)

St. Clair County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Audiology (0%)
- Inpatient Mental Health Treatment Facilities (64%)
- Occupational Therapy (0%)
- Physical Therapy (0%)
- Speech Therapy (85%)

Vernon County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Audiology (0%)
- Inpatient Mental Health Treatment Facilities (16%)
- Occupational Therapy (0%)
- Physical Therapy (0%)
- Psychologists/Other Therapy (8%)
- Speech Therapy (12%)

Blue Advantage Plus

St. Clair County:
- Inpatient Mental Health Treatment Facilities (44%)
- Speech Therapy (15%)

MO HealthNet Managed Care
GeoAccess Summary - 2008

Failed to achieve a score of at least 90%:

Mercy CarePlus - Central Region	Mercy CarePlus - Central Region (cont'd)
Benton County:	**Macon County, (cont'd):**
- Ambulatory Mental Health Treatment Facilities (0%)	- Nephrology (0%)
Boone County:	- Occupational Therapy (0%)
- Allergy (0%)	- Pediatric Subspecialty Care (0%)
- Ambulatory Mental Health Treatment Facilities (26%)	- Perinatology Services (87%)
- Infectious Disease (0%)	- Physical Medicine/Rehab (87%)
- Level I or Level II Trauma Unit (46%)	- Physical Therapy (0%)
- Neonatal Intensive Care Unit (13%)	- Speech Therapy (26%)
- Nephrology (1%)	**Maries County:**
- Pediatric Subspecialty Care (42%)	- Occupational Therapy (44%)
- Pediatrics (0%) (specialists only, not PCPs)	**Marion County:**
Camden County:	- Ambulatory Mental Health Treatment Facilities (30%)
- Ambulatory Mental Health Treatment Facilities (7%)	**Miller County:**
Chariton County:	- Ambulatory Mental Health Treatment Facilities (32%)
- Occupational Therapy (8%)	**Moniteau County:**
- Pediatric Subspecialty Care (0%)	- Ambulatory Mental Health Treatment Facilities (9%)
- Physical Therapy (8%)	- Infectious Disease (28%)
- Speech Therapy (62%)	- Level I or Level II Trauma Unit (45%)
Cole County:	- Neonatal Intensive Care Unit (23%)
- Allergy (68%)	- Pediatric Subspecialty Care (6%)
- Ambulatory Mental Health Treatment Facilities (0%)	**Monroe County:**
- Infectious Disease (0%)	- Infectious Disease (61%)
- Level I or Level II Trauma Unit (88%)	- Level I or Level II Trauma Unit (61%)
- Neonatal Intensive Care Unit (83%)	- Neonatal Intensive Care Unit (24%)
- Pediatrics (0%) (specialists only, not PCPs)	- Pediatric Subspecialty Care (46%)
Cooper County:	**Morgan County:**
- Ambulatory Mental Health Treatment Facilities (78%)	- Ambulatory Mental Health Treatment Facilities (0%)
- Neonatal Intensive Care Unit (84%)	**Pettis County:**
- Pediatric Subspecialty Care (0%)	- Ambulatory Mental Health Treatment Facilities (0%)
Howard County:	- Pediatric Subspecialty Care (8%)
- Infectious Disease (78%)	**Phelps County:**
- Neonatal Intensive Care Unit (37%)	- Audiology (80%)
- Pediatric Subspecialty Care (0%)	- Occupational Therapy (0%)
Laclede County:	**Pulaski County:**
- Ambulatory Mental Health Treatment Facilities (7%)	- Occupational Therapy (35%)
- Occupational Therapy (41%)	**Randolph County:**
- Physical Therapy (85%)	- Allergy (48%)
Linn County:	- Infectious Disease (4%)
- Allergy (83%)	- Level I or Level II Trauma Unit (6%)
- Inpatient Mental Health Treatment Facilities (79%)	- Neonatal Intensive Care Unit (0%)
- Neonatal Intensive Care Unit (83%)	- Occupational Therapy (11%)
- Nephrology (83%)	- Pediatric Subspecialty Care (0%)
- Occupational Therapy (0%)	- Physical Therapy (17%)
- Perinatology Services (73%)	**Saline County:**
- Pediatric Subspecialty Care (0%)	- Ambulatory Mental Health Treatment Facilities (41%)
- Physical Therapy (0%)	- Pediatric Subspecialty Care (0%)
- Speech Therapy (2%)	**Shelby County:**
Macon County:	- Allergy (59%)
- Allergy (0%)	- Infectious Disease (6%)
- Comprehensive Cardiac Services (87%)	- Level I or Level II Trauma Unit (6%)
- General Surgery (82%)	- Neonatal Intensive Care Unit (0%)
- Infectious Disease (2%)	- Nephrology (72%)
- Level I or Level II Trauma Unit (5%)	- Pediatric Subspecialty Care (1%)
- Neonatal Intensive Care Unit (0%)	

MO HealthNet Managed Care
GeoAccess Summary - 2008

Failed to achieve a score of at least 90%:

Healthcare USA - Central region

Audrain County:
- Psychologists/Other Therapy (86%)

Benton County:
- Ambulatory Mental Health Treatment Facilities (17%)
- Audiology (35%)
- Occupational Therapy (83%)
- Physical Therapy (83%)

Camden County:
- Ambulatory Mental Health Treatment Facilities (36%)
- Audiology (84%)

Laclede County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Occupational Therapy (82%)
- Physical Therapy (85%)

Linn County:
- Ambulatory Mental Health Treatment Facilities (66%)
- Inpatient Mental Health Treatment Facilities (79%)
- Occupational Therapy (77%)
- Physical Therapy (77%)

Macon County:
- Occupational Therapy (69%)
- Physical Therapy (69%)

Marion County:
- Ambulatory Mental Health Treatment Facilities (0%)
- Occupational Therapy (10%)
- Physical Therapy (10%)
- Psychologists/Other Therapy (0%)

Phelps County:
- Ambulatory Mental Health Treatment Facilities (23%)
- Occupational Therapy (29%)
- Physical Therapy (29%)

Pulaski County:
- Ambulatory Mental Health Treatment Facilities (25%)
- Occupational Therapy (47%)
- Physical Therapy (47%)

Ralls County:
- Ambulatory Mental Health Treatment Facilities (58%)
- Psychologists/Other Therapy (0%)

Shelby County:
- Psychologists/Other Therapy (19%)

Missouri Care

Benton County:
- Basic Hospitals (60%)
- Occupational Therapy (60%)
- Physical Therapy (60%)

Chariton County:
- Audiology (50%)

Laclede County:
- Inpatient Mental Health Treatment Facilities (41%)
- Physical Therapy (84%)

Linn County:
- Audiology (0%)
- Inpatient Mental Health Treatment Facilities (74%)
- Perinatology Services (72%)
- Secondary Hospitals (85%)

Macon County:
- Audiology (23%)
- Perinatology Services (87%)

Maries County:
- Basic Hospitals (44%)
- Occupational Therapy (44%)
- Physical Therapy (45%)

Marion County:
- Ambulatory Mental Health Treatment Facilities (27%)
- Basic Hospitals (0%)
- Dental (73%)
- Occupational Therapy (10%)
- Physical Therapy (10%)

Phelps County:
- Audiology (75%)
- Basic Hospitals (0%)
- Inpatient Mental Health Treatment Facilities (51%)
- Occupational Therapy (0%)
- Physical Therapy (0%)
- Secondary Hospitals (85%)
- Speech Therapy (87%)

Pulaski County:
- Basic Hospitals (78%)
- Inpatient Mental Health Treatment Facilities (38%)
- Occupational Therapy (52%)
- Physical Therapy (48%)

Ralls County:
- Basic Hospitals (17%)
- Dental (88%)
- Occupational Therapy (66%)
- Physical Therapy (66%)

Shelby County:
- Ambulatory Mental Health Treatment Facilities (87%)
- Basic Hospitals (89%)

MO HealthNet Managed Care
GeoAccess Summary - 2008
Failed to achieve a score of at least 90%:

Harmony Health Plan
Franklin County:
- Ambulatory Mental Health Treatment Facilities (58%)
- Basic Hospitals (82%)
- Hematology/Oncology (82%)
- Inpatient Mental Health Treatment Facilities (84%)
- Obstetrics/Gynecology (63%)
- Psychiatrist-Adult/General (81%)
- Rheumatology (76%)
Madison County:
- Basic Hospitals (16%)
- Inpatient Mental Health Treatment Facilities (82%)
- Occupational Therapy (16%)
- Physical Therapy (16%)
Pike County:
- Basic Hospitals (51%)
- Audiology (56%)
- Occupational Therapy (51%)
- Physical Therapy (51%)
St. Charles County:
- Dermatology (87%)
- Gastroenterology (88%)
- General Surgery (75%)
- Rheumatology (68%)
St. Francois County:
- Inpatient Mental Health Treatment Facilities (0%)
- Opthalmology (84%)
- Urology (37%)

Healthcare USA - Eastern Region
St. Francois County:
- Gastroenterology (84%)
- Pediatrics (83% - specialists only, not PCPs)

Mercy CarePlus - Eastern Region
St. Charles County:
- Psychiatrists-Adult/General (2%)
- Psychologists/Other Therapy (2%)
St. Louis City:
- Psychiatrists-Adult/General (38%)
- Psychologists/Other Therapy (4%)
St. Louis County:
- Psychiatrists-Adult/General (20%)
- Psychologists/Other Therapy (16%)

This page intentionally left blank

MO HealthNet Managed Care
SFY 2008 Member Grievance and Appeal Summary
Total Number of Member Grievances and Appeals Reported in SFY 2008*
Based on the Average Regional Monthly Enrollment**

	Grievances	Appeals
☐ Central Region	2.37	0.66
■ Eastern Region	8.44	0.72
☐ Western Region	7.47	2.38
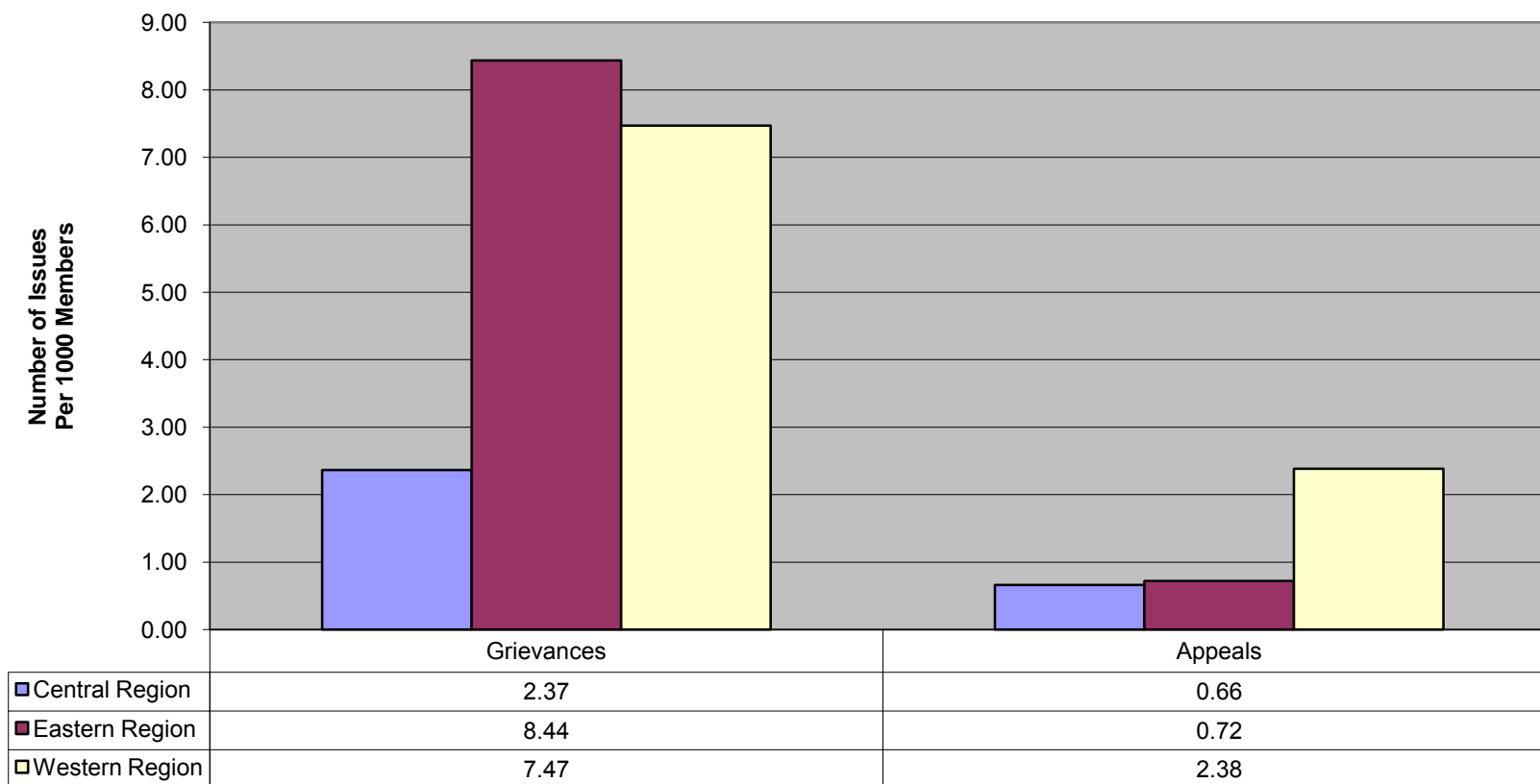
* Numerator
**Denominator

MO HealthNet Managed Care
SFY 2008 Provider Complaint, Grievance and Appeal Summary
Total Number of Complaints, Grievances and Appeals Reported in SFY 2008*
Based on the Average Regional Monthly Enrollment**

	Complaints	Grievances	Appeals
☐ Central Region	41.08	3.96	1.04
☐ Eastern Region	32.60	3.77	1.20
☐ Western Region	15.59	1.39	0.38
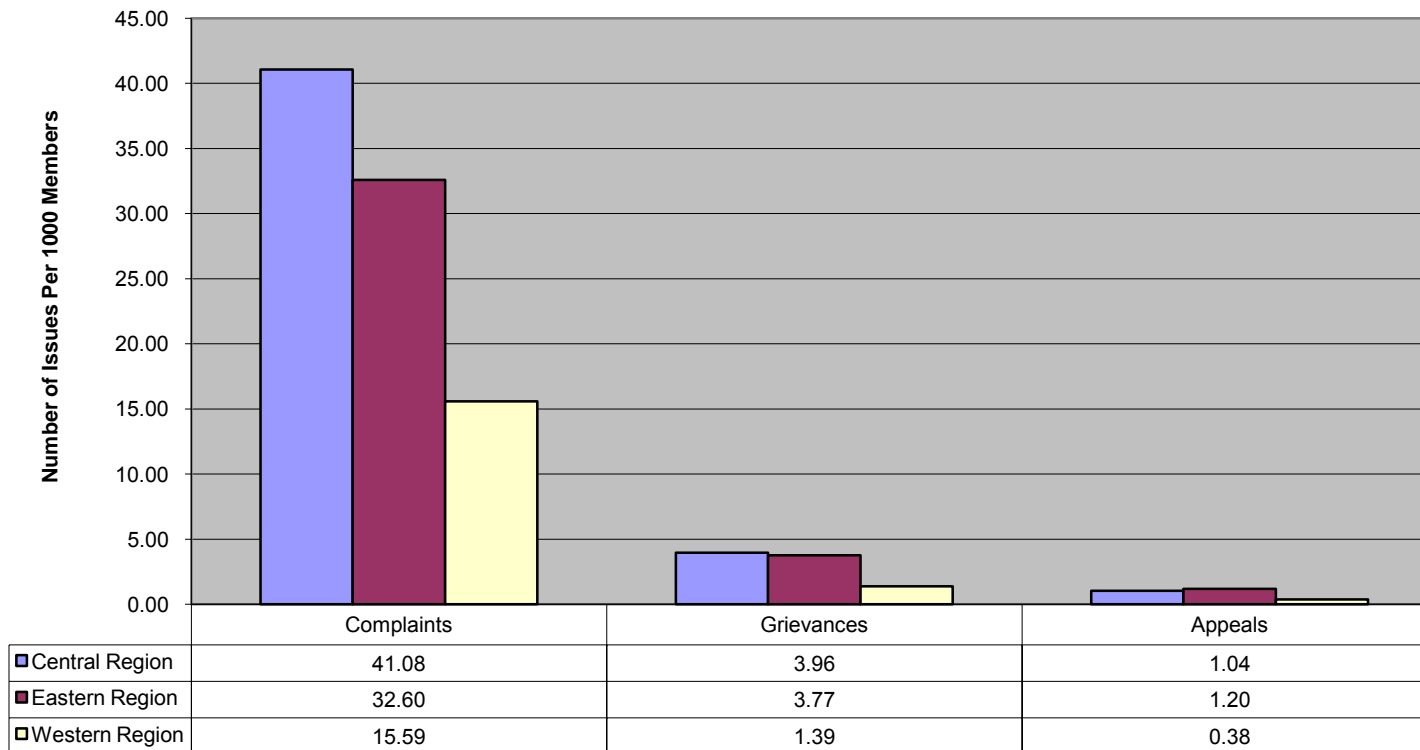
*Numerator
**Denominator

MO HealthNet Managed Care
Fraud and Abuse Annual Summary
SFY 2008

Central Region Annual Summary - SFY 2008				
	HCUSA	Mo Care	MCP	Total
Cases Closed*	7	39	1	47
Cases Open*	38	27	3	68
	45	**66**	**4**	**115**
	Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**
Cases Closed*	25.53%	70.21%	68.09%	14.89%	4.26%
Cases Open*	64.71%	20.59%	47.06%	52.94%	27.94%

Eastern Region Annual Summary - SFY 2008				
	Harmony	HCUSA	MCP	TOTAL
Cases Closed*	1	23	8	32
Cases Open*	0	120	56	176
	1	**143**	**64**	**208**
	Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**
Cases Closed*	84.38%	9.38%	21.88%	53.13%	34.38%
Cases Open*	83.52%	15.91%	30.11%	77.27%	47.16%

Western Region Annual Summary - SFY 2008					
	BA Plus	CMFHP	HCUSA	MCP	TOTAL
Cases Closed*	5	6	7	2	20
Cases Open*	2	32	23	7	64
	7	**38**	**30**	**9**	**84**
	Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**
Cases Closed*	75.00%	20.00%	50.00%	60.00%	5.00%
Cases Open*	82.81%	15.63%	65.63%	53.13%	39.06%

* Unique member/provider count

This page intentionally left blank.

1915b WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Mercy CarePlus		Missouri Care	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
6-Jul	42,890	17,323	40%	793	2%	24,774	58%
13-Jul	42,965	17,280	40%	827	2%	24,858	58%
20-Jul	43,084	17,299	40%	854	2%	24,931	58%
27-Jul	42,914	17,201	40%	876	2%	24,837	58%
3-Aug	43,013	17,202	40%	879	2%	24,932	58%
10-Aug	43,183	17,341	40%	876	2%	24,966	58%
17-Aug	42,979	17,274	40%	910	2%	24,795	58%
24-Aug	42,864	17,204	40%	899	2%	24,761	58%
31-Aug	42,859	17,146	40%	905	2%	24,808	58%
7-Sep	42,807	17,094	40%	934	2%	24,779	58%
13-Sep	42,965	17,122	40%	955	2%	24,888	58%
21-Sep	42,599	16,948	40%	959	2%	24,692	58%
28-Sep	42,732	17,011	40%	975	2%	24,746	58%
5-Oct	42,859	17,047	40%	1,009	2%	24,803	58%
11-Oct	42,818	16,970	40%	1,025	2%	24,823	58%
19-Oct	42,315	16,763	40%	1,018	2%	24,534	58%
26-Oct	42,312	16,714	40%	1,032	2%	24,566	58%
2-Nov	42,473	16,760	39%	1,049	2%	24,664	58%
9-Nov	42,582	16,795	39%	1,065	3%	24,722	58%
16-Nov	42,157	16,558	39%	1,080	3%	24,519	58%
26-Nov	42,292	16,629	39%	1,093	3%	24,570	58%
30-Nov	42,327	16,569	39%	1,107	3%	24,651	58%
7-Dec	42,625	16,671	39%	1,141	3%	24,813	58%
14-Dec	42,483	16,595	39%	1,149	3%	24,739	58%
21-Dec	43,649	17,264	40%	1,702	4%	24,683	57%
28-Dec	44,197	17,549	40%	1,870	4%	24,778	56%
4-Jan	44,657	17,794	40%	2,030	5%	24,833	56%
11-Jan	45,904	18,488	40%	2,379	5%	25,037	55%
18-Jan	47,533	19,544	41%	2,938	6%	25,051	53%
28-Jan	63,810	22,669	36%	5,165	8%	35,976	56%
1-Feb	64,668	22,974	36%	5,245	8%	36,449	56%
13-Feb	63,236	22,641	36%	5,140	8%	35,455	56%
15-Feb	63,067	22,584	36%	5,126	8%	35,357	56%
22-Feb	63,383	22,681	36%	5,152	8%	35,550	56%
29-Feb	63,793	22,853	36%	5,204	8%	35,736	56%
7-Mar	63,974	23,723	37%	5,190	8%	35,061	55%
14-Mar	64,517	23,962	37%	5,215	8%	35,340	55%
21-Mar	64,086	23,857	37%	5,210	8%	35,019	55%
28-Mar	64,209	23,977	37%	5,251	8%	34,981	54%
4-Apr	64,344	24,280	38%	5,243	8%	34,821	54%
11-Apr	64,453	24,287	38%	5,295	8%	34,871	54%
18-Apr	64,136	24,114	38%	5,400	8%	34,622	54%
25-Apr	64,248	24,136	38%	5,448	8%	34,664	54%
2-May	64,339	24,351	38%	5,441	8%	34,547	54%
9-May	64,529	24,393	38%	5,482	8%	34,654	54%
16-May	64,179	24,245	38%	5,437	8%	34,497	54%
23-May	64,314	24,322	38%	5,437	8%	34,555	54%
30-May	64,431	24,351	38%	5,466	8%	34,614	54%
6-Jun	64,492	24,410	38%	5,474	8%	34,608	54%
13-Jun	64,438	24,376	38%	5,451	8%	34,611	54%
20-Jun	64,198	24,317	38%	5,451	8%	34,430	54%
27-Jun	64,311	24,358	38%	5,495	9%	34,458	54%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

Attachment 2

1915b WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Mercy CarePlus	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
6-Jul	170,408	5,385	3.16%	107,522	63.10%	57,501	33.74%
13-Jul	170,814	5,493	3.22%	107,690	63.05%	57,631	33.74%
20-Jul	171,071	5,562	3.25%	107,845	63.04%	57,664	33.71%
27-Jul	**170,574**	**5,650**	**3.31%**	**107,450**	**62.99%**	**57,474**	**33.69%**
3-Aug	170,576	5,746	3.37%	107,460	63.00%	57,370	33.63%
10-Aug	170,871	5,833	3.41%	107,586	62.96%	57,452	33.62%
17-Aug	170,987	5,914	3.46%	107,671	62.97%	57,402	33.57%
24-Aug	171,273	6,055	3.54%	107,757	62.92%	57,461	33.55%
31-Aug	**170,267**	**5,997**	**3.52%**	**107,161**	**62.94%**	**57,109**	**33.54%**
7-Sep	170,480	6,190	3.63%	107,138	62.84%	57,152	33.52%
13-Sep	170,856	6,320	3.70%	107,341	62.83%	57,195	33.48%
21-Sep	171,289	6,426	3.75%	107,609	62.82%	57,254	33.43%
28-Sep	**170,501**	**6,486**	**3.80%**	**107,073**	**62.80%**	**56,942**	**33.40%**
5-Oct	170,718	6,623	3.88%	107,109	62.74%	56,986	33.38%
11-Oct	169,328	5,713	3.37%	106,744	63.04%	56,871	33.59%
19-Oct	170,266	6,936	4.07%	106,598	62.61%	56,732	33.32%
26-Oct	**169,920**	**7,077**	**4.16%**	**106,256**	**62.53%**	**56,587**	**33.30%**
2-Nov	169,704	7,168	4.22%	106,088	62.51%	56,448	33.26%
9-Nov	169,836	7,273	4.28%	106,126	62.49%	56,437	33.23%
16-Nov	168,837	7,324	4.34%	105,458	62.46%	56,055	33.20%
26-Nov	168,888	7,435	4.40%	105,421	62.42%	56,032	33.18%
30-Nov	**168,737**	**7,558**	**4.48%**	**105,236**	**62.37%**	**55,943**	**33.15%**
7-Dec	169,213	7,731	4.57%	105,413	62.30%	56,069	33.14%
14-Dec	168,759	7,754	4.59%	105,099	62.28%	55,906	33.13%
21-Dec	168,850	8,013	4.75%	104,859	62.10%	55,978	33.15%
28-Dec	**168,613**	**8,151**	**4.83%**	**104,600**	**62.04%**	**55,862**	**33.13%**
4-Jan	167,943	8,214	4.89%	104,051	61.96%	55,678	33.15%
11-Jan	168,100	8,259	4.91%	104,047	61.90%	55,794	33.19%
18-Jan	166,927	8,185	4.90%	103,325	61.90%	55,417	33.20%
28-Jan	**176,020**	**9,475**	**5.38%**	**107,962**	**61.34%**	**58,583**	**33.28%**
1-Feb	177,519	9,627	5.42%	108,792	61.28%	59,100	33.29%
13-Feb	173,385	9,477	5.47%	106,313	61.32%	57,595	33.22%
15-Feb	172,739	9,532	5.52%	105,933	61.33%	57,274	33.16%
22-Feb	172,655	9,596	5.56%	105,808	61.28%	57,251	33.16%
29-Feb	**173,015**	**9,675**	**5.59%**	**105,983**	**61.26%**	**57,357**	**33.15%**
7-Mar	172,811	9,593	5.55%	105,811	61.23%	57,407	33.22%
14-Mar	174,131	9,741	5.59%	106,587	61.21%	57,803	33.20%
21-Mar	173,265	9,736	5.62%	105,944	61.15%	57,585	33.24%
28-Mar	**173,648**	**9,844**	**5.67%**	**106,119**	**61.11%**	**57,685**	**33.22%**
4-Apr	173,708	9,842	5.67%	106,115	61.09%	57,751	33.25%
11-Apr	174,380	9,954	5.71%	106,454	61.05%	57,972	33.24%
18-Apr	173,513	10,118	5.83%	105,964	61.07%	57,431	33.10%
25-Apr	**173,715**	**10,225**	**5.89%**	**106,095**	**61.07%**	**57,395**	**33.04%**
2-May	173,661	10,258	5.91%	106,057	61.07%	57,346	33.02%
9-May	173,970	10,320	5.93%	106,172	61.03%	57,478	33.04%
16-May	173,018	10,317	5.96%	105,578	61.02%	57,123	33.02%
23-May	173,162	10,394	6.00%	105,581	60.97%	57,187	33.03%
30-May	**173,414**	**10,440**	**6.02%**	**105,769**	**60.99%**	**57,205**	**32.99%**
6-Jun	173,525	10,514	6.06%	105,747	60.94%	57,264	33.00%
13-Jun	173,371	10,481	6.05%	105,701	60.97%	57,189	32.99%
20-Jun	172,676	10,465	6.06%	105,352	61.01%	56,859	32.93%
27-Jun	**172,881**	**10,607**	**6.14%**	**105,518**	**61.04%**	**56,756**	**32.83%**

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

Attachment 3

1915b WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
WESTERN REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		HealthCare USA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total
6-Jul	98,248	23,920	24%	38,195	39%	33,392	34%	2,741	2.79%
13-Jul	98,827	24,084	24%	38,425	39%	33,492	34%	2,826	2.86%
20-Jul	98,979	24,114	24%	38,465	39%	33,524	34%	2,876	2.91%
27-Jul	98,586	23,997	24%	38,351	39%	33,330	34%	2,908	2.95%
3-Aug	98,528	23,944	24%	38,329	39%	33,283	34%	2,972	3.02%
10-Aug	98,863	23,972	24%	38,450	39%	33,405	34%	3,036	3.07%
17-Aug	98,837	23,985	24%	38,472	39%	33,302	34%	3,078	3.11%
24-Aug	99,097	24,040	24%	38,562	39%	33,350	34%	3,145	3.17%
31-Aug	98,478	23,855	24%	38,486	39%	33,025	34%	3,112	3.16%
7-Sep	98,761	23,944	24%	38,565	39%	33,017	33%	3,235	3.28%
13-Sep	98,933	24,016	24%	38,620	39%	33,010	33%	3,287	3.32%
21-Sep	98,659	23,860	24%	38,508	39%	32,944	33%	3,347	3.39%
28-Sep	98,215	23,755	24%	38,369	39%	32,669	33%	3,422	3.48%
5-Oct	98,332	23,774	24%	38,406	39%	32,661	33%	3,491	3.55%
11-Oct	98,820	23,856	24%	38,557	39%	32,801	33%	3,606	3.65%
19-Oct	99,057	23,851	24%	38,644	39%	32,849	33%	3,713	3.75%
26-Oct	99,350	23,877	24%	38,788	39%	32,896	33%	3,789	3.81%
2-Nov	99,423	23,896	24%	38,801	39%	32,842	33%	3,884	3.91%
9-Nov	99,517	23,941	24%	38,848	39%	32,794	33%	3,934	3.95%
16-Nov	98,854	23,775	24%	38,639	39%	32,487	33%	3,953	4.00%
26-Nov	98,897	23,722	24%	38,692	39%	32,476	33%	4,007	4.05%
30-Nov	98,682	23,640	24%	38,651	39%	32,354	33%	4,037	4.09%
7-Dec	99,008	23,701	24%	38,748	39%	32,429	33%	4,130	4.17%
14-Dec	98,618	23,621	24%	38,582	39%	32,303	33%	4,112	4.17%
21-Dec	98,943	23,460	24%	38,929	39%	32,142	32%	4,412	4.46%
28-Dec	98,991	23,433	24%	38,929	39%	32,092	32%	4,537	4.58%
4-Jan	98,996	23,377	24%	38,980	39%	31,959	32%	4,680	4.73%
11-Jan	99,495	23,410	24%	39,215	39%	31,989	32%	4,881	5%
18-Jan	99,150	23,254	23%	39,202	40%	31,467	32%	5,227	5%
28-Jan	108,767	24,825	23%	42,834	39%	34,136	31%	6,972	6.41%
1-Feb	110,019	25,404	23%	43,202	39%	34,371	31%	7,042	6%
13-Feb	107,661	25,163	23%	42,371	39%	33,375	31%	6,752	6%
15-Feb	107,086	25,207	24%	42,088	39%	33,129	31%	6,662	6%
22-Feb	107,211	25,293	24%	42,103	39%	33,059	31%	6,756	6%
29-Feb	107,563	25,304	24%	42,315	39%	33,107	31%	6,837	6.36%
7-Mar	107,856	25,379	24%	42,503	39%	32,986	31%	6,988	6%
14-Mar	108,908	25,527	23%	43,029	40%	33,266	31%	7,086	7%
21-Mar	108,327	25,322	23%	42,791	40%	33,095	31%	7,119	7%
28-Mar	108,618	25,411	23%	42,888	39%	33,147	31%	7,172	6.60%
4-Apr	108,781	25,346	23%	43,007	40%	33,193	31%	7,235	7%
11-Apr	109,072	25,378	23%	43,110	40%	33,284	31%	7,300	7%
18-Apr	108,524	25,103	23%	42,874	40%	33,206	31%	7,341	7%
25-Apr	108,724	25,142	23%	43,004	40%	33,195	31%	7,383	6.79%
2-May	108,772	25,154	23%	43,008	40%	33,188	31%	7,422	7%
9-May	109,075	25,208	23%	43,159	40%	33,257	30%	7,451	7%
16-May	108,411	25,121	23%	42,842	40%	33,028	30%	7,420	7%
23-May	108,778	25,198	23%	42,956	39%	33,106	30%	7,518	7%
30-May	108,871	25,227	23%	42,961	39%	33,131	30%	7,552	6.94%
6-Jun	109,158	25,275	23%	43,100	39%	33,210	30%	7,573	7%
13-Jun	108,893	25,181	23%	43,026	40%	33,127	30%	7,559	7%
20-Jun	108,298	25,004	23%	42,871	40%	32,892	30%	7,531	7%
27-Jun	108,676	25,072	23%	42,983	40%	33,033	30%	7,588	6.98%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

SCHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Mercy CarePlus		Missouri Care	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
6-Jul	5,346	2,424	45.34%	59	1.10%	2,863	53.55%
13-Jul	5,334	2,440	45.74%	65	1.22%	2,829	53.04%
20-Jul	5,340	2,433	45.56%	63	1.18%	2,844	53.26%
27-Jul	**5,352**	**2,463**	**46.02%**	**67**	**1.25%**	**2,822**	**52.73%**
3-Aug	5,219	2,404	46.06%	68	1.30%	2,747	52.63%
10-Aug	5,185	2,369	45.69%	68	1.31%	2,748	53.00%
17-Aug	5,172	2,341	45.26%	74	1.43%	2,757	53.31%
24-Aug	5,154	2,323	45.07%	79	1.53%	2,752	53.40%
31-Aug	**5,132**	**2,322**	**45.25%**	**80**	**1.56%**	**2,730**	**53.20%**
7-Sep	5,181	2,377	45.88%	76	1.47%	2,728	52.65%
13-Sep	5,182	2,387	46.06%	77	1.49%	2,718	52.45%
21-Sep	5,058	2,309	45.65%	73	1.44%	2,676	52.91%
28-Sep	**5,049**	**2,315**	**45.85%**	**78**	**1.54%**	**2,656**	**52.60%**
5-Oct	5,154	2,345	45.50%	83	1.61%	2,726	52.89%
11-Oct	5,271	2,392	45.38%	84	1.59%	2,795	53.03%
19-Oct	5,305	2,381	44.88%	98	1.85%	2,826	53.27%
26-Oct	**5,365**	**2,402**	**44.77%**	**104**	**1.94%**	**2,859**	**53.29%**
2-Nov	5,460	2,437	44.63%	106	1.94%	2,917	53.42%
9-Nov	5,505	2,445	44.41%	109	1.98%	2,951	53.61%
16-Nov	5,472	2,416	44.15%	108	1.97%	2,948	53.87%
26-Nov	5,477	2,403	43.87%	113	2.06%	2,961	54.06%
30-Nov	**5,526**	**2,426**	**43.90%**	**107**	**1.94%**	**2,993**	**54.16%**
7-Dec	5,611	2,446	43.59%	115	2.05%	3,050	54.36%
14-Dec	5,668	2,465	43.49%	116	2.05%	3,087	54.46%
21-Dec	5,864	2,583	44.05%	182	3.10%	3,099	52.85%
28-Dec	**5,962**	**2,634**	**44.18%**	**202**	**3.39%**	**3,126**	**52.43%**
4-Jan	6,094	2,689	44.13%	216	3.54%	3,189	52.33%
11-Jan	6,375	2,858	44.83%	266	4.17%	3,251	51.00%
18-Jan	6,676	3,027	45.34%	348	5.21%	3,301	49.45%
28-Jan	**8,428**	**3,392**	**40.25%**	**599**	**7.11%**	**4,437**	**52.65%**
1-Feb	8,566	3,456	40.35%	607	7.09%	4,503	52.57%
13-Feb	8,512	3,421	40.19%	627	7.37%	4,464	52.44%
15-Feb	8,419	3,390	40.27%	631	7.49%	4,398	52.24%
22-Feb	8,402	3,396	40.42%	627	7.46%	4,379	52.12%
29-Feb	**8,367**	**3,414**	**40.80%**	**609**	**7.28%**	**4,344**	**51.92%**
7-Mar	8,412	3,525	41.90%	600	7.13%	4,287	50.96%
14-Mar	8,091	3,394	41.95%	582	7.19%	4,115	50.86%
21-Mar	8,017	3,380	42.16%	563	7.02%	4,074	50.82%
28-Mar	**8,109**	**3,421**	**42.19%**	**576**	**7.10%**	**4,112**	**50.71%**
4-Apr	8,170	3,462	42.37%	588	7.20%	4,120	50.43%
11-Apr	8,253	3,495	42.35%	593	7.19%	4,165	50.47%
18-Apr	8,247	3,491	42.33%	614	7.45%	4,142	50.22%
25-Apr	**8,271**	**3,528**	**42.66%**	**605**	**7.31%**	**4,138**	**50.03%**
2-May	8,378	3,617	43.17%	618	7.38%	4,143	49.45%
9-May	8,445	3,644	43.15%	622	7.37%	4,179	49.48%
16-May	8,352	3,612	43.25%	602	7.21%	4,138	49.55%
23-May	8,343	3,584	42.96%	608	7.29%	4,151	49.75%
30-May	**8,395**	**3,597**	**42.85%**	**608**	**7.24%**	**4,190**	**49.91%**
6-Jun	8,515	3,631	42.64%	621	7.29%	4,263	50.06%
13-Jun	8,522	3,650	42.83%	627	7.36%	4,245	49.81%
20-Jun	8,387	3,598	42.90%	629	7.50%	4,160	49.60%
27-Jun	**8,425**	**3,617**	**42.93%**	**633**	**7.51%**	**4,175**	**49.55%**

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

SCHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total
6-Jul	16,925	347	2.05%	10,509	62.09%	6,069	35.86%
13-Jul	16,862	358	2.12%	10,447	61.96%	6,057	35.92%
20-Jul	16,952	369	2.18%	10,526	62.09%	6,057	35.73%
27-Jul	**16,924**	**376**	**2.22%**	**10,475**	**61.89%**	**6,073**	**35.88%**
3-Aug	16,946	380	2.24%	10,450	61.67%	6,116	36.09%
10-Aug	17,038	404	2.37%	10,476	61.49%	6,158	36.14%
17-Aug	17,085	423	2.48%	10,511	61.52%	6,151	36.00%
24-Aug	17,075	440	2.58%	10,531	61.67%	6,104	35.75%
31-Aug	**17,018**	**442**	**2.60%**	**10,477**	**61.56%**	**6,099**	**35.84%**
7-Sep	17,059	463	2.71%	10,484	61.46%	6,112	35.83%
13-Sep	16,998	467	2.75%	10,427	61.34%	6,104	35.91%
21-Sep	16,645	492	2.96%	10,151	60.99%	6,002	36.06%
28-Sep	**16,476**	**506**	**3.07%**	**10,032**	**60.89%**	**5,938**	**36.04%**
5-Oct	16,650	523	3.14%	10,152	60.97%	5,975	35.89%
11-Oct	16,799	549	3.27%	10,272	61.15%	5,978	35.59%
19-Oct	16,795	576	3.43%	10,300	61.33%	5,919	35.24%
26-Oct	**16,597**	**586**	**3.53%**	**10,135**	**61.07%**	**5,876**	**35.40%**
2-Nov	16,567	595	3.59%	10,096	60.94%	5,876	35.47%
9-Nov	16,590	608	3.66%	10,102	60.89%	5,880	35.44%
16-Nov	16,428	610	3.71%	10,007	60.91%	5,811	35.37%
26-Nov	16,378	622	3.80%	9,968	60.86%	5,788	35.34%
30-Nov	**16,304**	**618**	**3.79%**	**9,952**	**61.04%**	**5,734**	**35.17%**
7-Dec	16,404	635	3.87%	9,966	60.75%	5,803	35.38%
14-Dec	16,363	639	3.91%	9,926	60.66%	5,798	35.43%
21-Dec	16,068	646	4.02%	9,724	60.52%	5,698	35.46%
28-Dec	**16,009**	**654**	**4.09%**	**9,661**	**60.35%**	**5,694**	**35.57%**
4-Jan	16,056	658	4.10%	9,659	60.16%	5,739	35.74%
11-Jan	16,056	679	4.23%	9,647	60.08%	5,730	35.69%
18-Jan	15,823	684	4.32%	9,480	59.91%	5,659	35.76%
28-Jan	**16,502**	**819**	**4.96%**	**9,989**	**60.53%**	**5,694**	**34.50%**
1-Feb	16,738	834	4.98%	10,124	60.49%	5,780	34.53%
13-Feb	16,440	851	5.18%	9,938	60.45%	5,651	34.37%
15-Feb	16,254	848	5.22%	9,804	60.32%	5,602	34.47%
22-Feb	16,164	835	5.17%	9,756	60.36%	5,573	34.48%
29-Feb	**16,162**	**834**	**5.16%**	**9,752**	**60.34%**	**5,576**	**34.50%**
7-Mar	16,237	817	5.03%	9,784	60.26%	5,636	34.71%
14-Mar	15,526	788	5.08%	9,336	60.13%	5,402	34.79%
21-Mar	15,230	767	5.04%	9,189	60.33%	5,274	34.63%
28-Mar	**15,377**	**779**	**5.07%**	**9,277**	**60.33%**	**5,321**	**34.60%**
4-Apr	15,570	780	5.01%	9,420	60.50%	5,370	34.49%
11-Apr	15,668	757	4.83%	9,487	60.55%	5,424	34.62%
18-Apr	15,500	742	4.79%	9,391	60.59%	5,367	34.63%
25-Apr	**15,523**	**734**	**4.73%**	**9,420**	**60.68%**	**5,369**	**34.59%**
2-May	15,710	743	4.73%	9,525	60.63%	5,442	34.64%
9-May	15,807	747	4.73%	9,585	60.64%	5,475	34.64%
16-May	15,649	743	4.75%	9,488	60.63%	5,418	34.62%
23-May	15,778	769	4.87%	9,556	60.57%	5,453	34.56%
30-May	**15,823**	**768**	**4.85%**	**9,584**	**60.57%**	**5,471**	**34.58%**
6-Jun	16,075	781	4.86%	9,778	60.83%	5,516	34.31%
13-Jun	16,110	785	4.87%	9,809	60.89%	5,516	34.24%
20-Jun	15,930	785	4.93%	9,676	60.74%	5,469	34.33%
27-Jun	**15,953**	**780**	**4.89%**	**9,653**	**60.51%**	**5,520**	**34.60%**

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

SCHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
WESTERN REGION
STATE FISCAL YEAR 08 (1 JULY 2007 - 30 JUNE 2008)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		HealthCare USA		Mercy CarePlus	
		enrollment	% of total	enrollment	% of total	enrollment	% of total	enrollment	% of total
6-Jul	10,982	2,576	23.46%	4,968	45.24%	3,209	29.22%	229	2.09%
13-Jul	10,919	2,596	23.78%	4,920	45.06%	3,165	28.99%	238	2.18%
20-Jul	10,989	2,616	23.81%	4,960	45.14%	3,176	28.90%	237	2.16%
27-Jul	11,008	2,631	23.90%	4,984	45.28%	3,160	28.71%	233	2.12%
3-Aug	10,884	2,585	23.75%	4,925	45.25%	3,140	28.85%	234	2.15%
10-Aug	10,895	2,604	23.90%	4,913	45.09%	3,138	28.80%	240	2.20%
17-Aug	10,971	2,591	23.62%	4,973	45.33%	3,158	28.78%	249	2.27%
24-Aug	10,987	2,603	23.69%	4,967	45.21%	3,163	28.79%	254	2.31%
31-Aug	10,946	2,613	23.87%	4,949	45.21%	3,123	28.53%	261	2.38%
7-Sep	10,979	2,636	24.01%	4,949	45.08%	3,122	28.44%	272	2.48%
13-Sep	10,980	2,623	23.89%	4,948	45.06%	3,125	28.46%	284	2.59%
21-Sep	10,948	2,640	24.11%	4,929	45.02%	3,095	28.27%	284	2.59%
28-Sep	11,025	2,633	23.88%	4,972	45.10%	3,130	28.39%	290	2.63%
5-Oct	11,130	2,668	23.97%	5,045	45.33%	3,134	28.16%	283	2.54%
11-Oct	11,238	2,698	24.01%	5,100	45.38%	3,150	28.03%	290	2.58%
19-Oct	11,190	2,652	23.70%	5,103	45.60%	3,132	27.99%	303	2.71%
26-Oct	11,074	2,643	23.87%	5,076	45.84%	3,055	27.59%	300	2.71%
2-Nov	11,010	2,653	24.10%	5,041	45.79%	3,009	27.33%	307	2.79%
9-Nov	10,917	2,652	24.29%	4,996	45.76%	2,946	26.99%	323	2.96%
16-Nov	10,732	2,618	24.39%	4,895	45.61%	2,895	26.98%	324	3.02%
26-Nov	10,707	2,631	24.57%	4,874	45.52%	2,865	26.76%	337	3.15%
30-Nov	10,703	2,616	24.44%	4,881	45.60%	2,863	26.75%	343	3.20%
7-Dec	10,784	2,632	24.41%	4,925	45.67%	2,873	26.64%	354	3.28%
14-Dec	10,770	2,626	24.38%	4,916	45.65%	2,867	26.62%	361	3.35%
21-Dec	10,755	2,593	24.11%	4,912	45.67%	2,841	26.42%	409	3.80%
28-Dec	10,761	2,589	24.06%	4,930	45.81%	2,826	26.26%	416	3.87%
4-Jan	10,838	2,577	23.78%	4,986	46.00%	2,847	26.27%	428	3.95%
11-Jan	10,938	2,608	23.84%	4,984	45.57%	2,890	26.42%	456	4.17%
18-Jan	10,944	2,555	23.35%	5,022	45.89%	2,865	26.18%	502	4.59%
28-Jan	12,029	2,732	22.71%	5,450	45.31%	3,144	26.14%	703	5.84%
1-Feb	12,241	2,824	23.07%	5,541	45.27%	3,177	25.95%	699	5.71%
13-Feb	12,205	2,866	23.48%	5,543	45.42%	3,104	25.43%	692	5.67%
15-Feb	12,085	2,847	23.56%	5,501	45.52%	3,066	25.37%	671	5.55%
22-Feb	12,024	2,836	23.59%	5,456	45.38%	3,054	25.40%	678	5.64%
29-Feb	12,083	2,817	23.31%	5,448	45.09%	3,106	25.71%	712	5.89%
7-Mar	12,154	2,814	23.15%	5,459	44.92%	3,142	25.85%	739	6.08%
14-Mar	11,624	2,670	22.97%	5,254	45.20%	2,977	25.61%	723	6.22%
21-Mar	11,437	2,622	22.93%	5,192	45.40%	2,895	25.31%	728	6.37%
28-Mar	11,544	2,616	22.66%	5,246	45.44%	2,930	25.38%	752	6.51%
4-Apr	11,656	2,646	22.70%	5,289	45.38%	2,954	25.34%	767	6.58%
11-Apr	11,728	2,671	22.77%	5,331	45.46%	2,976	25.38%	750	6.39%
18-Apr	11,575	2,625	22.68%	5,261	45.45%	2,949	25.48%	740	6.39%
25-Apr	11,569	2,622	22.66%	5,252	45.40%	2,950	25.50%	745	6.44%
2-May	11,728	2,669	22.76%	5,318	45.34%	2,980	25.41%	761	6.49%
9-May	11,831	2,690	22.74%	5,380	45.47%	2,996	25.32%	765	6.47%
16-May	11,633	2,646	22.75%	5,299	45.55%	2,931	25.20%	757	6.51%
23-May	11,661	2,645	22.68%	5,297	45.42%	2,957	25.36%	762	6.53%
30-May	11,735	2,649	22.57%	5,342	45.52%	2,976	25.36%	768	6.54%
6-Jun	11,837	2,650	22.39%	5,402	45.64%	3,006	25.39%	779	6.58%
13-Jun	11,844	2,650	22.37%	5,391	45.52%	3,027	25.56%	776	6.55%
20-Jun	11,648	2,629	22.57%	5,283	45.36%	2,971	25.51%	765	6.57%
27-Jun	11,689	2,659	22.75%	5,277	45.15%	2,993	25.61%	760	6.50%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

01/18/08-Auto assignment processing in 17 new Managed Care counties resulted in an increased number of participants enrolled.

Enrollment dates of 01/28/08 and 02/01/08 include enrollees with future stop dates

ASSIGNMENT TYPES - ALL WAIVERS
ALL MO HEALTHNET MANAGED CARE REGIONS - STATEWIDE
STATE FISCAL YEAR 2008 (1 JULY 2007 - 30 JUNE 2008)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Recipient Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	2,820	364	2,763	**5,947**	1,131	11,975	7,489	**20,595**	**26,542**
AUGUST	3,084	446	3,151	**6,681**	1,111	13,011	7,462	**21,584**	**28,265**
SEPTEMBER	3,380	452	3,462	**7,294**	986	14,104	5,679	**20,769**	**28,063**
OCTOBER	3,839	491	3,836	**8,166**	1,079	19,156	6,377	**26,612**	**34,778**
NOVEMBER	4,161	579	4,208	**8,948**	1,050	18,311	6,224	**25,585**	**34,533**
DECEMBER	4,336	556	4,051	**8,943**	997	18,695	4,606	**24,298**	**33,241**
JANUARY	3,779	630	3,815	**8,224**	1,195	20,470	19,250	**40,915**	**49,139**
FEBRUARY	19,501	3,599	16,515	**39,615**	1,230	18,065	9,452	**28,747**	**68,362**
MARCH	3,928	590	3,901	**8,419**	1,356	18,442	10,724	**30,522**	**38,941**
APRIL	4,526	553	3,977	**9,056**	1,346	26,051	10,559	**37,956**	**47,012**
MAY	4,013	534	4,311	**8,858**	1,276	18,289	10,329	**29,894**	**38,752**
JUNE	3,196	474	3,162	**6,832**	1,244	16,248	6,557	**24,049**	**30,881**
TOTAL ASSIGNMENTS:	60,563	9,268	57,152	**126,983**	14,001	212,817	104,708	**331,526**	**458,509**
*TYPE CODE ASSIGNMENT RATE:	13.21%	2.02%	12.46%	**27.69%**	3.05%	46.42%	22.84%	**72.31%**	**100.00%**

*total number of each code divided by total of all codes   Source: Various Adhocs Revised   07-Jul-08

1915b MO HealthNet Managed Care ASSIGNMENTS
ALL MC+ REGIONS - STATEWIDE
STATE FISCAL YEAR 2008 (1 JULY 2007 - 30 JUNE 2008)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Participant Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	2,342	323	2,321	**4,986**	1,131	7,715	5,837	**14,683**	**19,669**
AUGUST	2,523	393	2,611	**5,527**	1,111	8,575	5,873	**15,559**	**21,086**
SEPTEMBER	2,774	400	2,889	**6,063**	986	9,031	4,495	**14,512**	**20,575**
OCTOBER	3,096	420	3,135	**6,651**	1,079	11,750	5,026	**17,855**	**24,506**
NOVEMBER	3,378	510	3,445	**7,333**	1,050	11,651	4,916	**17,617**	**24,950**
DECEMBER	3,428	472	3,273	**7,173**	997	12,007	3,658	**16,662**	**23,835**
JANUARY	3,004	535	3,036	**6,575**	1,195	13,364	14,467	**29,026**	**35,601**
FEBRUARY	15,117	3,167	12,705	**30,989**	1,230	12,433	7,282	**20,945**	**51,934**
MARCH	3,131	507	3,134	**6,772**	1,356	12,442	8,216	**22,014**	**28,786**
APRIL	3,648	477	3,209	**7,334**	1,346	16,514	7,995	**25,855**	**33,189**
MAY	3,222	470	3,494	**7,186**	1,276	12,318	7,987	**21,581**	**28,767**
JUNE	2,591	406	2,579	**5,576**	1,244	10,894	5,013	**17,151**	**22,727**
TOTAL ASSIGNMENTS:	48,254	8,080	45,831	**102,165**	14,001	138,694	80,765	**233,460**	**335,625**
*TYPE CODE ASSIGNMENT RATE:	14.38%	2.41%	13.66%	**30.44%**	4.17%	41.32%	24.06%	**69.56%**	**100.00%**

*total number of each code divided by total of all codes   Source: Verizon Reports   Revised: 07/07/08

Note: The increase in reassigns starting in Sept. is being researched through a SPAR.
The projection is the increase could be due to changes performed by FSD through more frequent review of cases.

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2006, are higher than normal.

MO HealthNet for Kids (Title XXI) ASSIGNMENTS
ALL MC+ REGIONS - STATEWIDE
STATE FISCAL YEAR 2008 (1 JULY 2007 - 30 JUNE 2008)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Participant Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	478	41	442	961	0	4,260	1,652	5,912	6,873
AUGUST	561	53	540	1,154	0	4,436	1,589	6,025	7,179
SEPTEMBER	606	52	573	1,231	0	5,073	1,184	6,257	7,488
OCTOBER	743	71	701	1,515	0	7,406	1,351	8,757	10,272
NOVEMBER	783	69	763	1,615	0	6,660	1,308	7,968	9,583
DECEMBER	908	84	778	1,770	0	6,688	948	7,636	9,406
JANUARY	775	95	779	1,649	0	7,106	4,783	11,889	13,538
FEBRUARY	4,384	432	3,810	8,626	0	5,632	2,170	7,802	16,428
MARCH	797	83	767	1,647	0	6,000	2,508	8,508	10,155
APRIL	878	76	768	1,722	0	9,537	2,564	12,101	13,823
MAY	791	64	817	1,672	0	5,971	2,342	8,313	9,985
JUNE	605	68	583	1,256	0	5,354	1,544	6,898	8,154
TOTAL ASSIGNMENTS:	12,309	1,188	11,321	24,818	0	74,123	23,943	98,066	122,884
*TYPE CODE ASSIGNMENT RATE:	10.02%	0.97%	9.21%	20.20%	0.00%	60.32%	19.48%	79.80%	100.00%

*total number of each code divided by total of all codes   Source: Verizon Reports   Revised: 07/07/08
\

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2007, are higher than normal.

Attachment 10

1915b MO HEALTHNET MANAGED CARE TRANSFERS BETWEEN HEALTH PLANS
ALL MO HEALTHNET MANAGED CARE REGIONS STATEWIDE
STATE FISCAL YEAR 2008 (1 JULY 2007 - 30 JUNE 2008)

	Eastern Region	Central Region	Western Region	Total
July				
# of Transfers:	1,091	238	454	1,783
% of Total MC+ Transfers:	61.19%	13.35%	25.46%	100.00%
August				
# of Transfers:	570	245	414	1,229
% of Total MC+ Transfers:	46.38%	19.93%	33.69%	100.00%
September				
# of Transfers:	475	241	348	1,064
% of Total MC+ Transfers:	44.64%	22.65%	32.71%	100.00%
October				
# of Transfers:	687	234	506	1,427
% of Total MC+ Transfers:	48.14%	16.40%	35.46%	100.00%
November				
# of Transfers:	788	322	511	1,621
% of Total MC+ Transfers:	48.61%	19.86%	31.52%	100.00%
December				
# of Transfers:	832	277	564	1,673
% of Total MC+ Transfers:	49.73%	16.56%	33.71%	100.00%
January				
# of Transfers:	726	341	836	1,903
% of Total MC+ Transfers:	38.15%	17.92%	43.93%	100.00%
February				
# of Transfers:	677	449	588	1,714
% of Total MC+ Transfers:	39.50%	26.20%	34.31%	100.00%
March				
# of Transfers:	827	1,658	856	3,341
% of Total MC+ Transfers:	24.75%	49.63%	25.62%	100.00%
April				
# of Transfers:	1,281	1,351	967	3,599
% of Total MC+ Transfers:	35.59%	37.54%	26.87%	100.00%
May				
# of Transfers:	682	667	561	1,910
% of Total MC+ Transfers:	35.71%	34.92%	29.37%	100.00%
June				
# of Transfers:	555	370	418	1,343
% of Total MC+ Transfers:	41.33%	27.55%	31.12%	100.00%
Total Transfer TO:	9191	6393	7023	22607

This summary information is from the monthly report, Transfers Between Health Plans.
Source: IFOX

MO HealthNet For Kids (Title XXI) TRANSFERS BETWEEN HEALTH PLANS
ALL MC+ REGIONS STATEWIDE
STATE FISCAL YEAR 2008 (1 JULY 2007 - 30 JUNE 2008)

	Eastern Region	Central Region	Western Region	Total
July				
# of Transfers:	221	62	104	387
% of Total MC+ Transfers:	57.11%	16.02%	26.87%	100.00%
August				
# of Transfers:	123	60	87	270
% of Total MC+ Transfers:	45.56%	22.22%	32.22%	100.00%
September				
# of Transfers:	100	63	76	239
% of Total MC+ Transfers:	41.84%	26.36%	31.80%	100.00%
October				
# of Transfers:	127	60	115	302
% of Total MC+ Transfers:	42.05%	19.87%	38.08%	100.00%
November				
# of Transfers:	182	81	112	375
% of Total MC+ Transfers:	48.53%	21.60%	29.87%	100.00%
December				
# of Transfers:	210	72	126	408
% of Total MC+ Transfers:	51.47%	17.65%	30.88%	100.00%
January				
# of Transfers:	167	73	227	467
% of Total MC+ Transfers:	35.76%	15.63%	48.61%	100.00%
February				
# of Transfers:	168	138	159	465
% of Total MC+ Transfers:	36.13%	29.68%	34.19%	100.00%
March				
# of Transfers:	256	462	252	970
% of Total MC+ Transfers:	26.39%	47.63%	25.98%	100.00%
April				
# of Transfers:	305	407	240	952
% of Total MC+ Transfers:	32.04%	42.75%	25.21%	100.00%
May				
# of Transfers:	178	195	147	520
% of Total MC+ Transfers:	34.23%	37.50%	28.27%	100.00%
June				
# of Transfers:	119	112	101	332
% of Total MC+ Transfers:	35.84%	33.73%	30.42%	100.00%
Total Transfer TO:	2,156	1,785	1,746	5,687

This summary information is from the monthly report, Transfers Between Health Plans.
Source: IFOX

MO HealthNet Managed Care
Supplemental Security Income (SSI) Opt-Outs
SFY 2008

PROCESSED BY	#	Percent
Quality Services	0	0.00%
PSI	486	89.34%
RSU	58	10.66%
TOTAL	**544**	**100.00%**

REGION	#	Percent
Eastern	191	35.11%
Central	191	35.11%
Western	162	29.78%
TOTAL	**544**	**100.00%**

1115 Members	#	Percent
Eastern Region	39	54.93%
Western Region	19	26.76%
Central Region	13	18.31%
TOTAL	**71**	**100.00%**

WAIVER	#	Percent
1915(b)	473	86.95%
1115	71	13.05%
TOTAL	**544**	**100.00%**

REASONS	#	Percent
Better Benefits	207	38.05%
No Information Provided by PSI	10	1.84%
Doctor Takes Straight Medicaid	179	32.90%
Did Not Meet Opt Out Criteria	0	0.00%
Other	113	20.77%
Too Many Referrals	4	0.74%
Caseworker Suggested	2	0.37%
Too Many Doctors	28	5.15%
Better Doctors	1	0.18%
TOTAL	**544**	**100.00%**

STATUS	#	Percent
Disenrollment from a Plan	319	58.64%
Disenrollment prior to Enrollment	209	38.42%
Re-enrollment	14	2.57%
Opt Out Denied	0	0.00%
Other	2	0.37%
TOTAL	**544**	**100.00%**

MO HealthNet Managed Care Special Health Care Needs
SFY 2008

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL
East													
Harmony	42	60	54	52	103	83	68	73	39	61	83	47	**765**
HCUSA	230	224	197	150	286	267	194	220	179	203	227	203	**2,580**
Molina	123	129	112	103	205	166	138	147	116	126	141	123	**1,629**
Central													
HCUSA	36	44	47	17	60	45	143	219	154	183	118	64	**1,130**
MO Care	66	67	69	45	112	95	96	302	228	134	204	114	**1,532**
Molina	1	6	7	11	21	12	63	91	65	37	47	12	**373**
West													
BA+	33	68	59	44	68	69	57	76	41	68	61	44	**688**
CMFHP	92	93	101	75	163	119	114	120	137	113	130	97	**1,354**
HCUSA	73	73	60	59	117	74	71	72	51	77	74	60	**861**
Molina	18	32	19	24	37	27	78	68	76	30	47	22	**478**
TOTAL	**714**	**796**	**725**	**580**	**1,172**	**957**	**1,022**	**1,388**	**1,086**	**1,032**	**1,132**	**786**	**11,390**

MO HealthNet Managed Care
Race Report for SFY 2008

Race	Central Region Number of Members			Western Region Number of Members				Eastern Region Number of Members			Total	Percent
	Molina	HCUSA	MO Care	HCUSA	Molina	CMFHP	BA+	Harmony	Molina	HCUSA		
Asian	23	57	115	132	40	198	96	30	100	154	945	0.17%
Black	772	4,443	7,783	20,128	3,142	19,868	14,268	8,818	35,760	91,520	206,502	38.02%
Hispanic	46	160	382	592	123	662	573	186	948	1,331	5,003	0.92%
Multi-Racial	80	343	570	438	94	546	355	72	273	394	3,165	0.58%
Other	7	42	61	138	65	156	119	23	59	63	733	0.13%
Unable to determi	97	607	993	1,572	438	1,834	1,087	529	2,355	3,140	12,652	2.33%
White	8,154	33,037	46,900	30,991	9,703	43,467	25,012	9,900	49,579	57,362	314,105	57.84%
TOTAL	**9,179**	**38,689**	**56,804**	**53,991**	**13,605**	**66,731**	**41,510**	**19,558**	**89,074**	**153,964**	**543,105**	

Race	Central Region Number of Members			Total	Percent
	Molina	HCUSA	MO Care		
Asian	23	57	115	195	0.19%
Black	772	4,443	7,783	12,998	12.42%
Hispanic	46	160	382	588	0.56%
Multi-Racial	80	343	570	993	0.95%
Other	7	42	61	110	0.11%
Unable to determin	97	607	993	1,697	1.62%
White	8,154	33,037	46,900	88,091	84.16%
TOTAL	**9,179**	**38,689**	**56,804**	**104,672**	

Race	Eastern Region Number of Members			Total	Percent
	Harmony	Molina	HCUSA		
Asian	30	100	154	284	0.11%
Black	8,818	35,760	91,520	136,098	51.83%
Hispanic	186	948	1,331	2,465	0.94%
Multi-Racial	72	273	394	739	0.28%
Other	23	59	63	145	0.06%
Unable to de	529	2,355	3,140	6,024	2.29%
White	9,900	49,579	57,362	116,841	44.49%
TOTAL	**19,558**	**89,074**	**153,964**	**262,596**	

Race	Western Region Number of Members				Total	Percent
	HCUSA	Molina	CMFHP	BA+		
Asian	132	40	198	96	466	0.27%
Black	20,128	3,142	19,868	14,268	57,406	32.65%
Hispanic	592	123	662	573	1,950	1.11%
Multi-Racial	438	94	546	355	1,433	0.81%
Other	138	65	156	119	478	0.27%
Unable to determin	1,572	438	1,834	1,087	4,931	2.80%
White	30,991	9,703	43,467	25,012	109,173	62.09%
TOTAL	**53,991**	**13,605**	**66,731**	**41,510**	**175,837**	

MO HealthNet Managed Care
Language Report for SFY 2008

Language	Eastern Region	Western Region	Central Region	Percent
ASL	3	0	0	**0.00%**
Arabic	109	61	7	**0.01%**
Cambodian	3	2	3	**0.00%**
Chinese	40	7	4	**0.00%**
English	168,181	98,581	57,073	**53.03%**
Haitian	6	3	0	**0.00%**
Japanese	0	0	1	**0.00%**
Laotian	2	1	0	**0.00%**
Other	881	368	207	**0.19%**
Polish	6	1	0	**0.00%**
Romanian	3	0	0	**0.00%**
Russian	29	3	56	**0.05%**
Spanish	482	1,183	172	**0.16%**
Tagalog	3	0	1	**0.00%**
Vietnamese	132	66	10	**0.01%**
~Missing	99,426	80,216	50,085	**46.54%**
	269,306	**180,492**	**107,619**	**100.00%**

Attachment 16-1

Children's Mercy Family Health Partners -MO HealthNet
Corporate Dashboard Indicators

#	Indicator	Numerator	Denominator	Benchmark	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FY Avg
1	Interest Paid	Total amount of interest paid on claims in the period		n/a	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
2	TPL Recoveries and Cost Avoidance	Report dollar amount of TPL Recoveries made during the quarter		n/a		$49,914			$25,329			$56,038			$24,320		$37,621
3	COB Savings	Total quarterly dollar amount calculated as savings from paying a secondary carrier		n/a													
4	Days of Claims on hand	Current Claims Inventory	Average Daily production	< 10 days	4.2	3.8	3.2	2.8	2.2	3.6	3.6	3.81	3.92	3.89	4.12	4.89	3.3
5	Average Turn-Around Time	# of days from receipt to process	Total # of Claims	< 20 days	8.1	9.5	8.5	7.8	5.8	6.2	7.6	9.28	7.12	8.95	7.82	9.26	7.6
6	Claims Processing Accuracy	Total Points Scored	Total Points Reviewed	>98%	100.0%	100.0%	99.8%	99.8%	99.4%	99.3%	99.95.%	99.14%	99.52%	99.17%	99.52%	99.64%	99.7%
7	Claims Financial Accuracy	$ Paid in Error (of Reviewed Claims)	Total $ Reviewed	>98%	100.0%	100.0%	100.0%	100.0%	99.9%	99.0%	99.78%	99.23%	99.63%	99.90%	99.96%	99.97%	99.8%
8	Claims Overall Accuracy	This is a weighted average	66% Financial & 34% Processing (%)	>98%	100.0%	100.0%	99.9%	99.9%	99.7%	99.1%	99.83%	99.20%	99.60%	99.65%	99.82%	99.86%	99.8%
9	Claims Receipt to Pay	(# of days to pay electronic X % of electronic claims) + (# of days to pay paper X % of paper claims)	Total # of Claims	<30 days	20.3	20.2	19.4	15.5	14.4	14.2	15.27	17.36	15.52	18.38	15.85	16.97%	17.3
10	Code Review Savings	Total dollar amount calculated as savings from claims code review		n/a	$36,504	$41,836	$37,226	$32,643	$69,377	$47,546	$29,943	$34,484	$29,187	$34,509	$45,528	$32,030	$44,189
11	Call Abandonment Rate	As calculated by ACD		5%	4%	4%	5%	4%	3%	2%	5.0%	3.0%	2%	2%	2%	2%	4%
12	Average Response Time to Calls	As calculated by ACD		< 30 sec average hold time in period	10	13	14	12	12	9	8 sec	8 sec	8 sec	8 sec	8 sec	8 Sec	12
13	# of Member Packets Mailed	Total number of member packets mailed, both Reissue and New		n/a	2,047	2,532	2,106	3,662	2,863	1,093	4,362	1,767	3,370	3,382	2,135	1,881	2384
14	HCFA Sanction Report	# of participating providers on the HCFA Sanction List in the period	# of participating providers in the period	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
15	Total Marketing Contacts	Report # of Contacts		175 / month	100	122	69	692	126	101	88	128	72	100	111	140	202
16	Individual Event Contacts	Report # of Contacts		300 / month	1,113	3,241	1,509	515	918	365	183	379	450	1,339	360	507	1277
17	Extension Group Contacts	Report # of Contacts Numbers are Food Power/Food Power Young Adventure		1,250 / month	Seasonal / 583	Seasonal / 398	640 / 397	2080 / 767	952 / 553	480 / 660	480	1,317	2,001	1,244	85	0	717/858
18	Turnover Ratio of Adverse Determination Appeals	# of Adverse Determinations overturned in the period	# of adverse determinations received in the period	n/a	66%	33%	75%	25%	0%	100%	33%	44%	0%	0%	50%	33%	50%
19	Pregnancy Notification	# of pregnancy cases seen for 1st OB visit 1st, 2nd or 3rd trimester	# of PNF's received	94% rec'd in 1st and 2nd Trimester - based on 2006 average of 93.3%													
			1ST		58%	50%	50%	50%	55%	38%	57%	68%	66%	55%	66%	66%	50%
			2ND		32%	43%	41%	45%	36%	54%	34%	26%	25%	34%	24%	27%	42%
			1&2		90%	93%	91%	95%	91%	92%	91%	94%	91%	89%	90%	93%	92%
			3RD		10%	7%	9%	5%	9%	8%	9%	6%	9%	11%	10%	7%	8%
20	Case Management Activity Report	Prepare report in format shown as Attachment 1		n/a													
21	UM Activity Report	Prepare report in format shown as Attachment 2		n/a													
22	QM Activity	Prepare report in format shown as Attachment 3		n/a													
23	HI Activity	Prepare report in format shown as Attachment 4		n/a													

Children's Mercy Family Health Partners - MO HealthNet
Case Management Report

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FY
# of newly opened Peds Cases	11	15	15	6	17	8	8	13	1	13	2	4	113
# of ongoing Peds Cases	47	62	53	53	62	67	68	57	36	49	45	46	645
# of closed Peds Cases	20	0	24	6	8	3	7	24	22	0	6	3	123
# of Peds Level 3 Acuity	24	26	26	24	25	31	24	20	16	16	19	19	270
# of Peds Level 2 Acuity	15	20	18	18	25	24	30	25	13	24	14	14	240
# of Peds Level 1 Acuity	8	16	9	11	12	12	14	12	7	9	12	13	135
Number of cases in outreach												19	19
# of newly opened Adult Cases	3	2	4	3	3	0	0	0	0	0	2	4	21
# of ongoing Adult Cases	16	16	18	18	11	1	1	0	0	0	1	3	85
# of closed Adults Cases	22	2	2	3	10	10	0	1	0	0	1	2	53
# of Adults Level 3 Acuity	0	2	2	2	2	0	0	0	0	0	1	1	10
# of Adults Level 2 Acuity	1	2	4	2	2	0	0	0	0	0	2	6	19
# of Adults Level 1 Acuity	15	12	12	14	7	1	1	0	0	0	0	0	62
Number of cases in outreach												17	17
# of newly opened OB Cases	16	11	2	20	12	14	19	16	24	16	15	13	178
# of ongoing OB Cases	42	45	43	48	53	59	59	74	72	81	81	71	728
# of Closed OB cases	105	8	4	15	7	8	19	1	26	7	15	23	238
Number of cases in outreach												28	28
# of newly opened lead cases	3	8	14	6	7	2	2	2	1	1	1	4	51
# of ongoing lead cases	48	51	62	57	52	52	49	49	42	38	30	27	557
# of closed lead cases	8	5	3	11	12	2	5	2	8	5	9	7	77
# of newly opened Consent Decree Cases	11	13	4	1	6	4	7	5	4	9	4	8	76
# of ongoing Consent Decree Cases	116	123	119	100	106	103	95	88	81	88	86	89	1194
# of closed Consent Decree Cases	0	6	8	20	0	7	15	12	11	2	6	5	92

Case Management Attachment 1

Attachment 16-3

Children's Mercy Family Health Partners - MO HealthNet
Utilization Activity Report

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FY
Monthly Statistics													
# Inpt Days Total	1421	1289	1423	1355	1248	1233	1490	1394	1449	1357	1381	1303	16343
Inpt Days Denied	5	9	8	10	2	2	11	3	10	7	1	3	71
Inpt Cases Denied	4	5	5	8	2	2	6	2	5	5	1	3	48
Outpt Cases Denied	23	24	26	18	19	11	8	16	15	11	11	17	199
Days/1000	390	354	388	368	338	336	401	352	362	339	343	325	4296
Admits/1000	114	112	117	103	102	101	124	102	115	104	99	96	1289
# Admits	414	407	429	379	377	370	460	404	461	414	398	385	4898
# Adult Admits	235	254	240	213	215	201	230	194	200	154	166	158	2460
# Ped Admits	179	153	189	166	162	169	230	210	261	260	232	227	2438
# Total OB Admits	192	212	191	165	179	174	196	162	220	207	171	180	2249
Avg. LOS Adult	2.7	2.6	2.7	2.9	2.6	2.6	3.9	4.3	3.8	4.0	4.4	4.3	3.4
Avg. LOS Peds	4.5	4.1	4.1	4.5	4.2	4.2	2.6	2.7	2.6	2.9	2.8	2.7	3.5
Avg. LOS OB	2.5	2.5	2.7	2.7	2.4	2.5	2.5	2.6	2.5	2.6	2.5	2.6	2.6
Avg. LOS All Adm	3.4	3.2	3.3	3.6	3.3	3.3	3.2	3.5	3.1	3.3	3.5	3.4	3.3
C/S % - PNF database	25%	21%	28%	23%	20%		24%	31%	30%	32%	27%	29%	26.4%
Physician Reviews													
Health Services Cases sent to Medical Director Review	53	55	55	48	31	28	50	68	67	74	55	51	635
Average Turn-around time for HS MD review	1	1	1	1	1	1	1	1	1	1	1	1	1
Health Services Cases sent to external review	0	0	0	0	0	0	0	1	0	0	0	0	1
Average Turn-around time for HS external review	0	0	0	0	0	0	0	1	0	0	0	0	1
Cost of external review cases	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47.00	$0.00	$0.00	$0.00	$0.00	$47.00
Nurse Advice													
# of FHP Calls Taken (CMH)	622	536	839	1526	1536	1471	1757	1949	1825	1563	1444	1345	16413
# of FHP Calls Taken (McKesson)	292	300	293	318	270	280	285	328	305	275	293	255	3494
# of FHP calls Taken	914	836	1132	1844	1806	1751	2042	2277	2130	1838	1737	1600	19907
Nurse Advice Call Statistics (Aggregate)													
CMH													FY
Average Speed of Answer	2.6	3.2	3.6	3.4	3.8	4.6	3.4	3.2	4.2	3.4	2.6	3	3.4
Abandonment Rate	0.03	0.04	0.01	0.02	0.04	0.06	0.04	0.04	0.05	0.04	0.04	0.03	0.03
Average Length of Call	15.7	10.7	10.2	10.4	9.78	10.1	10.2	11.2	12.4	11.5	10.75	11.3	11.18
McKesson													
Average Speed of Answer	20	11	31	11	26	22	10	11	14	25	24	19	18.66
Abandonment Rate	6.7	4.4	3.6	2.8	4.5	6.1	2.2	5.1	5.3	3.6	3.3	6.5	4.5
Average Length of Call	6.9	6.3	6.6	7.1	7	6.6	6.3	7.6	7.6	6.75	7.1	7.1	6.9

Children's Mercy Family Health Partners
MO HealthNet Provider Complaint, Grievance, & Appeal Log

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FY
							19	14	13	6	11	13	
Total Complaints	**65**	**35**	**19**	**18**	**17**	**16**							**246**
FHP	63	34	15	17	16	16	17	13	11	5	8	7	222
Behavioral Health (New Directions)	2	1	3	1	1	0	0	1	2	1	2	4	18
Dental (Bridgeport)	0	0	1	0	0	0	2	0	0	1	1	2	7
FHP Average Days for Resolution (10)	2.5	2.8	3.4	2.6	4.0	3.6	2.7	4.7	3	7.5	3.1	4.1	3.7
Total Grievances	**2**	**4**	**2**	**1**	**2**	**2**	**2**	**0**	**3**	**2**	**2**	**0**	**22**
FHP	1	4	1	1	2	2	2	0	3	2	1	0	19
Behavioral Health (New Directions)	1	0	1	0	0	0	0	0	0	0	1	0	3
Dental (Bridgeport)	0	0	0	0	0	0	0	0	0	0	0	0	0
FHP Average Days for Resolution (30)	3.5	20.5	1	0.0	1.0	1.0	5	0	3	11	11.5	0	4.8
Total Appeals	**1**	**0**	**0**	**0**	**2**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**5**
FHP	1	0	0	0	2	2	0	0	0	0	0	0	5
Behavioral Health (New Directions)	0	0	0	0	0	0	0	0	0	0	0	0	0
Dental (Bridgeport)	0	0	0	0	0	0	0	0	0	0	0	0	0
FHP Average Days for Resolution (60)	0.0	0.0	0.0	0.0	16.0	3.5	0.0	0.0	0.0	0.0	0.0	0.0	1.6
Total Inquiries	**2**	**4**	**2**	**7**	**11**	**5**	**3**	**1**	**3**	**5**	**6**	**3**	**52**

Children's Mercy Family Health Partners
MC+ Member Grievance, & Appeal Log

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	FY
Total Grievances	**30**	**39**	**15**	**27**	**30**	**14**	**19**	**20**	**17**	**16**	**25**	**20**	**272**
FHP	0	0	0	0	2	0	1	2	2	1	2	3	13
Behavioral Health (New Directions)	1	3	0	0	1	0	1	1	0	1	1	0	9
Dental (Bridgeport)	0	0	0	0	0	0	0	0	2	2	0	0	4
Transportation	28	36	15	26	30	13	17	17	13	12	22	17	218
FHP Average Days for Resolution (30)	4.4	6.4	6.6	8.2	5.8	4.0	9.4	8	9.4	9.1	13.4	8.3	7.8
Total Appeals	**5**	**6**	**3**	**4**	**2**	**1**	**2**	**8**	**5**	**3**	**1**	**2**	**42**
FHP	2	5	3	4	2	1	2	5	3	0	1	2	30
Behavioral Health (New Directions)	1	0	0	0	0	0	0	0	0	0	0	0	1
Dental (Bridgeport)	2	1	0	0	0	0	0	3	2	3	0	0	11
FHP Average Days for Resolution (60)	0.0	14.0	0.0	32.0	1.0		5	17.9	17.4	51.3	7	13	13.2
Total Inquiries	2	1	0	2	1	0	3	0	3	1	0	1	14
Total State Fair Hearing	0	2	1	0	2	1	2	1	1	1	1	0	12
Total Quality of Care	6	1	6	3	1	0	0	1	0	0	0	0	18

Attachment 16-5

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals 2008
Health Coach													
Active Health Coaching	27-Jan	25-Jan	27	37	53	65	78	91	92	93			588
Phone Contacts	65	109	102	211	144	199	220	185	230	257			1722
Letters Sent	28	58	81	89	41	54	99	44	59	92			645
Packets Sent	24	51	60	84	37	48	66	29	41	54			494
Member Clinic Visits	6	2	2	2	7	4	8	3	8	12			54
Member Home Visits	3	1	1	5	6	5	10	3	10	10			54
Members referred to Healthy Hawks	1	0	1	1	1	3	4	3	0	2			16
Members referred to PHIT Kids	1	2	1	2	1	1	0	1	0	0			9
Members referred to Home Health	4	1	0	0	0	2	2	0	2	1			12
Referrals Received	42	114	82	343	50	49	46	48	67	49			890
HRA Referrals	4	94	259	183	226	68	25	16	5	6			886
Education Coordinator													
Asthma Offices Completed (MO)										21			
HeLP Offices Completed (MO)										8			

Health Improvement Attachment 4

Attachment 17

Blue Advantage Plus

Quality Improvement Work Plan - 2008

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Approve	3377	Patient Safety Work Plan	Annually		Banks, Cheryl	QC	1/7/2008	2/4/2008			
Update	1576	Patient Safety Initiatives Update	Annually		Banks, Cheryl	QC	1/7/2008	2/4/2008			
Analysis	3336	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	1/9/2008	1/9/2008			
Report	3757	Accessibility of Utilization Management Services	Semi-Annuall		Banks, Cheryl	M4	1/15/2008				
Analysis	3352	EPSDT outcomes reporting	Semi-Annuall		Wadman, Wes	BA+OC	1/15/2008	1/15/2008			
Analysis	3552	Screening Member Complaints to Identify Potential Office Site Deficiencies (Jul - Dec)	Semi-Annuall		Sitzmann, Bryan	QC	2/4/2008	1/7/2008			
Analysis	1606	Analysis of Complaints of Quality of Care	Annually		Sitzmann, Bryan	QC	2/4/2008	2/4/2008			
Monitor	586	Medical Director Interrater Reliability – Medical Management Department	Annually		Sitzmann, Bryan		2/4/2008	2/4/2008			
Analysis	1668	Annual Adverse Quality of Care Summary	Annually		Sitzmann, Bryan	QC	2/4/2008	2/4/2008			
Audit	1437	Oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	2/8/2008	4/25/2008			
Audit	1114	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	2/8/2008	8/9/2008			
Report	3566	Quarterly Appeals Timeliness Report for PRS - Q4	Quarterly	PRS	Banks, Cheryl	DOC	2/8/2008	4/25/2008			
Report	3501	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	2/15/2008	2/15/2008			

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Work Plan	3484	Medical and Pharmacy Management Committee Work Plan (Pharmacy and Medical Aspects)	Annually		Neff, Owen	MPMC	2/15/2008	2/15/2008	QC/M	3/4/2008	5/5/2008
Approve	2888	Medical Management Program Description – Evaluation and Approval	Annually		Wederquist, Sandy	ADMIN	3/3/2008	3/3/2008			
Report	3648	Outcome and ROI measures for Care Management	Annually		Williamson, Blake	QC	3/3/2008	3/3/2008			
Analysis	84	MTM Survey Performance Measures Report (Claims, Customer Service, Membership)	Quarterly		Bibler, Mary	QC	3/3/2008	3/3/2008			
Analysis	868	Case Management Customer Satisfaction Survey	Annually		Wederquist, Sandy	M4	3/15/2008	3/15/2008	QC	4/7/2008	4/7/2008
Approve	53	Quality Improvement System Description	Annually		Bowen, Shelley	QC	3/26/2008	3/26/2008	BOD	5/15/2008	5/14/2008
Approve	55	BCBSKC Quality Improvement Program Work Plan	Annually		Bowen, Shelley	QC	3/26/2008	3/26/2008	BOD	5/15/2008	5/14/2008
Approve	3376	BCBSKC Annual Appraisal of the Quality Improvement Program	Annually		Bowen, Shelley	QC	3/26/2008	3/26/2008	BOD	5/15/2008	5/14/2008
Training	1573	Showcase of Quality	Annually		Bowen, Shelley	SC	4/1/2008	4/1/2008			
Approve	3526	Continuity and Coordination of Care Work Plan	Annually		Banks, Cheryl	QC	4/7/2008	10/6/2008			
Update	3650	A Healthier You - Annual Update	Annually		Hochart, Cindy	QC	4/7/2008	4/7/2008			
Report	3745	Credentialing Quality Improvement Projects	Annually		James, Kathy	QC	4/7/2008	4/7/2008			
Analysis	3286	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	4/10/2008	4/10/2008			
Update	1472	Update Contract Amendment Claims template	Annually	All	Turner, Maryann	DOC	4/12/2008				

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Approve	1473	Annual Review of Corporate Policy VI-12 Delegation Performance Assessment and Oversight	Annually		Bowen, Shelley	DOC	4/12/2008				
Update	3223	Update Contract Amendment QI template	Annually	All	Bowen, Shelley	DOC	4/12/2008				
Audit	1434	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	4/12/2008	4/25/2008			
Update	1470	Update Contract Amendment UM template	Annually	All	Banks, Cheryl	DOC	4/12/2008				
Update	1469	Update Contract Amendment Credentialing template	Annually	All	James, Kathy	DOC	4/12/2008				
Report	3651	Annual Delegation and Marketing Guidelines Compliance Survey	Annually		Brennan, Judy	DOC	4/12/2008	4/25/2008	QC/M	4/15/2008	5/5/2008
Report	3279	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	4/12/2008	4/25/2008			
Audit	1644	Conduct oversight audit of NDBH for claims payment activities (Medicaid)	Quarterly	NDBH	Turner, Maryann	DOC	4/12/2008	8/9/2008			
Update	3190	Update Contract Amendment CM template	Annually	NDBH	Banks, Cheryl	DOC	4/12/2008	4/25/2008			
Update	3722	Care Connection Advisory Committee Conflict of Interest and Confidentiality Statements	Annually		Hochart, Cindy	CCAC	4/15/2008				
Approve	549	Milliman Care Guidelines - Annual Review and Approval of Prior Auth and Concurrent Review	Annually		Williamson, Blake	MPMC	4/18/2008	4/18/2008	QC/M	6/15/2008	5/5/2008
Work Plan	917	Medical Policy Committee Work Plan	Annually		Sitzmann, Bryan	MPC	4/28/2008	4/28/2008	QC/M	5/15/2008	5/15/2008
Analysis	3252	Brand Strength Measure MTM Survey	Annually		Parrish, Susan	QC	5/5/2008	5/5/2008			
Analysis	3703	Hospital Quality Initiatives Analysis	Annually		Cure, Chad	QC	5/5/2008	8/4/2008			

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	1080	BCBSKC Board of Directors Conflict of Interest and Confidentiality Statements	Annually		O'Connor, Sharon	BOD	5/12/2008	5/12/2008			
Approve	3318	Clinical Guidelines for PCP Management of ADHD - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2008				
Approve	895	Clinical Guidelines for Evaluation and Management of Chronic Heart Failure in the Adult - Review Guideline	Biennially		Wadman, Wes	CCAC	5/15/2008				
Approve	3452	Clinical Guideline for Management of Anticoagulant Therapy for Non-Valvular Atrial Fibrilation	Biennially		Wadman, Wes	CCAC	5/15/2008				
Approve	888	Clinical Guidelines for the Health Management of Pregnant Women - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2008				
Approve	896	Clinical Guidelines for Hypertension - Management in the Adult (Review & Revise as needed)	Biennially		Wadman, Wes	CCAC	5/15/2008				
Report	3502	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	5/15/2008	5/15/2008			
Approve	3609	Clinical Guideline for Secondary prevention of myocardial infarction (Beta blocker after acute MI) - Review and revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2008				
Approve	3451	Clinical Guideline for Post Acute MI Management - Review and revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2008				
Communi	859	Review and Revision of Provider Office Guide	Semi-Annuall		Burge, Wayne	QC	6/2/2008	6/2/2008			
Update	3400	Review/Revise Vendor Application Forms for Delegated Activities	Annually	All	Bowen, Shelley	DOC	6/14/2008				
Monitor	1129	Denials and Overturned Denials (Regular semi-annual Reporting)	Semi-Annuall	NDBH	McFall, Paula	ND DOC	6/19/2008	6/19/2008			
Report	3713	NDBH Survey of BA+ Member Satisfaction	Biennially	NDBH	McFall, Paula	ND DOC	6/19/2008	6/19/2008			
Report	1592	NDBH Annual QI Report - Annual Appraisal, System Description and Work Plan	Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2008	6/19/2008			

Attachment 17

Activity Type	ID	Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Report	3638	NDBH Telephone Access	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2008	6/19/2008			
Update	3160	Medicaid Mental Health Committee Meeting Report	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2008	6/19/2008			
Monitor	1125	Complaints & Grievances (NDBH Regular Semi-annual Reporting)	Semi-Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2008	6/19/2008			
Report	3569	Suicide Statistics Annual Report	Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2008	6/19/2008	QC/M	8/4/2009	8/4/2008
Update	3445	Cultural Competency Activities Update	Annually	NDBH	Smith, Garth	ND DOC	6/19/2008	6/19/2008			
Monitor	3216	Member Communications	Annually	NDBH	Smith, Garth	ND DOC	6/19/2008	6/19/2008			
Monitor	1132	Utilization Trend Reports from NDBH (Semi-annual Report)	Semi-Annually	NDBH	Woodring, Lisa	ND DOC	6/19/2008	6/19/2008			
Monitor	1138	Appeals of NDBH UM Determinations (Regular semi-annually Report)	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2008	6/19/2008			
Update	3177	Health and Behavior Committee Update	Semi-Annually	NDBH	Bardwell, Judy	ND DOC	6/19/2008	6/19/2008	QC/M	8/4/2008	8/4/2008
Approve	1142	Approval of SOP for Continuity and Coordination of Care (Collaboration between NDBH and BCBSKC)	Annually	NDBH	Bardwell, Judy	HBC	6/26/2008	7/24/2008			
Update	3363	Conflict of Interest and Confidentiality Statements – Obstetric Advisory Committee	Annually		Williamson, Blake	OBAC	6/28/2008				
Update	3364	Conflict of Interest and Confidentiality Statements – Practice Manager's Advisory Committee	Annually		Burge, Wayne	PMAC	6/28/2008				
Approve	3610	Annual Review of P&P for Clinical Guideline Development and Revision	Annually		Wadman, Wes	CCAC	7/9/2008				
Analysis	3292	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	7/10/2008	7/14/2008			

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	3351	EPSDT reporting	Semi-Annuall		Wadman, Wes	BA+OC	7/13/2008	7/14/2008			
Report	3764	Accessibility of Utilization Management Services	Semi-Annuall		Banks, Cheryl	M4	7/15/2008				
Analysis	1590	Blue-Advantage Plus ADD/ADHD Drugs Utilization Report	Annually		Neff, Owen	BA+OC	7/15/2008	7/15/2008			
Update	1603	Conflict of Interest and Confidentiality Statements for the RAC	Annually		Williamson, Blake	RAC	7/26/2008				
Analysis	3500	Hospital Quality Initiatives Analysis	Annually		Bowen, Shelley	HPQC	7/31/2008	7/22/2008			
Analysis	3551	Screening Member Complaints to Identify Potential Office Site Deficiencies (Jan - Jun)	Semi-Annuall		Sitzmann, Bryan	QC	8/4/2008	8/4/2008			
Analysis	1669	Annual Sentinel Events Summary Report	Annually		Sitzmann, Bryan	QC	8/4/2008	8/4/2008			
Report	3637	Approval of NDBH Annual Quality Improvement Appraisal, System Description and Work Plan	Annually	NDBH	Bowen, Shelley	QC	8/4/2008	8/4/2008			
Audit	9	Annual Evaluation of Quality Improvement System for NDBH	Annually	NDBH	Bowen, Shelley	DOC	8/4/2008	8/9/2008			
Audit	1436	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	8/9/2008	8/9/2008			
Audit	1112	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	8/9/2008				
Report	3567	Semi-Annual Appeals Timeliness Report for PRS-	Semi-Annual	PRS	Banks, Cheryl	DOC	8/9/2008	8/9/2008			
Report	3282	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	8/9/2008	8/9/2008			
Audit	3389	Oversight Audit for NDBH Member Grievances & Provider Complaints	Annually	NDBH	Brennan, Judy	DOC	8/12/2008				

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Report	3503	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	8/15/2008	8/15/2008			
Update	1079	Medical Advisory Committee Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	MAC	8/28/2008				
Upate	3464	Emergency Room Advisory Committee - Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	ERAC	8/30/2008				
Approve	3284	BA+ Annual Appraisal of the Quality Improvement Program and Work Plan	Annually		Brennan, Judy	BA+OC	9/1/2008		BA+BOD	10/1/2008	
Analysis	3511	MTM Survey Performance Measures Report (Claims, Customer Service, Membership)	Quarterly		Bibler, Mary	QC	9/8/2008	9/8/2008			
Update	1075	Peer Review Committee Conflict of Interest and Confidentiality Statements	Annually		Sitzmann, Bryan	PRC	9/15/2008				
Update	3365	Corporate Credentials Committee - Conflict of Interest and Confidentiality Statements	Annually		Britton, Loretta	CCC	9/21/2008				
Analysis	3295	Analyze Membership for Primary Language Spoken	Quarterly		Brennan, Judy	BA+OC	10/9/2008				
Update	7	Review and update audit tools for claims	Annually	All	Turner, Maryann	DOC	10/11/2008				
Update	8	Review and update audit tools for credentialing	Annually	All	James, Kathy	DOC	10/11/2008				
Update	4	Review and update audit tools for utilization management	Annually	All	Nickles, Gwen	DOC	10/11/2008				
Update	3	Review and update Quality Improvement audit tools	Annually	All	Bowen, Shelley	DOC	10/11/2008				
Update	3672	Review and update audit tools for Pharmacy Patient Safety	Annually	Argus	Neff, Owen	DOC	10/11/2008				
Update	3698	Review and Update Audit Tools for Member Grievances and Provider Complaints	Annually	NDBH	Brennan, Judy	DOC	10/11/2008				

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Audit	1113	Conduct oversight audit of NDBH for claims payment activities (Medicaid).	Quarterly	NDBH	Turner, Maryann	DOC	10/11/2008				
Report	3317	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	10/11/2008				
Audit	1435	Conduct oversight audit of Doral Dental claims payment activities (Medicaid).	Quarterly	Doral	Turner, Maryann	DOC	10/11/2008				
Update	1627	Review and update audit tools for Complaints & Grievances	Annually	All	Fahlstrom, Sherlyn	DOC	10/11/2008				
Audit	1646	Complaints and Grievances Oversight Audit - NDBH	Annually	NDBH	Fahlstrom, Sherlyn	DOC	10/11/2008				
Approve	3455	Delegated Vendor Communication Grid Review	Annually	All	Bowen, Shelley	DOC	10/11/2008				
Update	37	Review and update audit tools for member appeals and grievances	Annually	All	Fahlstrom, Sherlyn	DOC	10/11/2008				
Approve	343	Physician Office Guidelines for Medical Record Documentation Review Standards	Annually		Banks, Cheryl	PRC	10/15/2008				
Update	3359	Medical and Pharmacy Management Committee-COI and Confidentiality Statements	Annually		Neff, Owen	MPMC	10/17/2008				
Upate	3371	Chiropractic Care Committee - Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	ChCC	10/30/2008				
Update	3576	Customer Service Satisfaction Survey	Annually		Parrish, Susan	QC	11/3/2008				
Monitor	87	Compliance With Post-Hospital MI Care Guidelines	Annually		Wadman, Wes	CCAC	11/12/2008				
Report	3740	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	11/15/2008				
Approve	889	Clinical Guidelines for Preventive Services for Pediatric Patients and Adult Patients - Review and Revise as needed	Annually		Wadman, Wes	CCAC	11/15/2008				

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Audit	3625	Audit to insure members are notified of closed formulary changes.	Annually		Bardwell, Judy	ADMIN	11/15/2008				
Analysis	3271	Language Line/Cultural Competency Analysis	Annually		Parrish, Susan	QC	12/1/2008				
Analysis	3783	Medicaid/BA+ CAHPS® Results and Trend Analysis	Annually		Parrish, Susan	QC	12/1/2008				
Communi	3504	Review and Revision of Provider Office Guide	Semi-Annuall		Burge, Wayne	QC	12/1/2008				
Update	1451	Business Continuity Project	Annually		McKelvy, Norma	QC	12/1/2008				
Update	3179	Health and Behavior Committee Update	Semi-Annuall	NDBH	Bardwell, Judy	ND DOC	12/11/2008		QC/M	2/15/2009	
Report	3531	NDBH Telephone Access	Semi-Annuall	NDBH	McFall, Paula	ND DOC	12/11/2008				
Monitor	1127	Complaints & Grievances (NDBH Regular semi-annual Reporting)	Semi-Annuall	NDBH	Chaput, Suzanne	ND DOC	12/11/2008				
Monitor	1131	Denials and Overturned Denials (Regular semi-annual Reporting)	Semi-Annuall	NDBH	McFall, Paula	ND DOC	12/11/2008				
Monitor	1134	Utilization Reports (semi-annual Report)	Semi-Annuall	NDBH	Woodring, Lisa	ND DOC	12/11/2008				
Monitor	1140	Appeals of NDBH UM Determinations (Regular semi-annually Reporting)	Semi-Annuall	NDBH	McFall, Paula	ND DOC	12/11/2008				
Update	3162	Medicaid Mental Health Committee Meeting Report	Semi-Annuall	NDBH	McFall, Paula	ND DOC	12/11/2008				
Report	3314	Medical Transportation Management (MTM) Quarterly Meeting	Quarterly	MTM	Brennan, Judy	DOC	12/13/2008				
Review	3210	Annual Evaluation of Quality Improvement System for Doral Dental	Annually	Doral	Bowen, Shelley	DOC	12/13/2008				

Attachment 17

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	1144	Preventive Health Programs for Behavioral Health - Review (Educational Materials)	Annually	NDBH	Chaput, Suzanne	HBC	12/20/2008				
Work Plan	1358	Medical Advisory Committee Work Plan (MAC)	Semi-Annuali		Williamson, Blake	MAC	12/28/2008		QC/M	2/15/2009	
Report	3265	Best Practices from Blues Research Roundtable Report	Annually		Parrish, Susan	QC	1/15/2009				
Approve	1553	Clinical Guidelines for Migraine - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	3/12/2009				
Approve	893	Clinical Guidelines for Evaluation and Management of Diabetes - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Approve	890	Clinical Guidelines for Asthma Management - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Approve	3453	Clilnical Guidelines for Management of Depression for the Primary Care Physician (PCP)	Biennially		Wadman, Wes	CCAC	5/15/2009				
Approve	891	Clinical Guidelines for COPD - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Monitor	52	Vendor Delegation Assessment Survey	Biennially	All	Bowen, Shelley	DOC	6/14/2009				
Approve	1143	Clinical Guidelines for Depression for Behavioral Health Practitioners - Review and Revise as needed	Biennially	NDBH	Wadman, Wes	CCAC	7/15/2009				
Approve	3635	Clinical Guidelines for ADHD for Behavioral Health Practitioners - Review and Revise as needed	Biennially	NDBH	Wadman, Wes	CCAC	7/15/2009				
Approve	892	KCQC Clinical Guidelines for Management of Hyperlipidemia - CAD Risk Modification - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	9/15/2009				
Report	3630	URAC Accreditation Application Submission - HUM, PCRED, CM	Triennially		Bardwell, Judy	ADMIN	9/30/2010				

Attachment 18

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
INFORMATION TECHNOLOGY			
1. Upgrade Systems			
	a) Purchase and install new Exchange Enterprise email server(s)	3/31/2008	
	b) Replace FHPImage	6/30/2008	
	c) upgrade connection between Riss and the cave to support additional replication	3/31/2008	
	d) Plan for and move all Riss building staff to 2400 Pershing	11/01/2008	
	e) Increase disk space on both AS/400s	03/31/2008	
	f) Convert Commsys 2.0 letters to v3.0	05/01/2008	
	g) Plan for new Wichita office	04/01/2008	
2. Disaster Recovery			
	a) Evaluate and recommend a solution for making our email system "disaster-proof"	06/30/2008	
	b) Purchase and install backup phone system at the cave	06/30/2008	
	c) Purchase and install backup SAN at cave and begin replicating between the two.	7/31/2008	
3. Information Systems Security			
	a) Evaluate, purchase and implement an email encryption solution	2/15/2008	
	b) Evaluate, purchase and implement a file/disk encryption solution.	6/30/2008	
	c) Write internal incident response procedures	7/31/2008	
	d) Install Perimeter Intrusion Detection systems.	8/31/2008	
	e) Install video surveillance at the cave	9/30/2008	

1

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
	f) Install video surveillance in data center at 2420 Pershing.	~~11/01/08~~ 2/1/2009	
	g) Install removable media management and control	4/30/2208	
	h) Purchase and install a Test environment for our network and servers	3/31/2008	
4. System Enhancements			
	a) Locate and evaluate technologies which will help improve CMFHP's position in our markets.	12/31/2008	
	b) Convert NSF format encounter reporting to 837 format for the state of Missouri	12/31/2008	
	c) Upgrade Code Review from V7 to V9	03/31/2008	
	d) Install eCAS detailed call reporting	9/30/2008	
	e) Enhance Imaging system to support remote scanning of Medical records in conjunction with HEDIS MRR	4/1/2008	
	f) Evaluate the need for predictive modeling software geared toward identifying high-risk members.	3/31/2008	
	g) Upgrade existing Intranet site to Sharepoint.	5/31/2008	
	h) Install wallboard server and wallboard agents on PreCert PCs.	2/28/2008	
	i) Purchase and install Aldon source control software.	06/30/2008	
	j) Complete CARE v2	05/31/2008	
	k) Complete Online Institutional claims entry system.	03/15/2008	
	l) Complete rollout of SalesLogix CRM software.	3/31/2008	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
	m) Enhance MC400 to support both capturing rendering provider on professional claims and pricing claims based on the rendering provider.	5/23/2008	
5. Staffing			
	a) Hire a 2nd Network Systems Analyst	3/31/2008	
	b) Hire another .NET Programmer	5/31/2008	
OPERATIONS			
6. Insure MO	System and benefit set up	3/15/08	
7. Healthy Choices	System and benefit set up	1/1/09	
8. Staffing	Evaluate the need for Sr. DQ analyst or auditor for 08	4/30/08	
CLAIMS			
9. COB Processing	• Complete real-time validation • Train all Sr. analysts on MO/KS processing	2/28/08	
10. Code Review V9	• Complete V9 testing • Implement MO • Test & implement KS	2/28/08 2/28/08 3/31/08	
11. Encounter Reject Process	• Complete work from 06 • Program queues by error type • Reporting capability • Implement encounter void and replace • MO & KS	MO to determine	
12. Batch Classes	Build and implement new batch classes to support additional fields needed for HCFA and UB04	2/28/08	
13. Batch Manager	Evaluate opportunity to use verification module in Batch Manager to assist with quality review	3/31/08	

Attachment 18

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
14. Posting Refunds	• Catch up with 2007 posting of refund checks • Develop process/training to complete refunds and voids within 7 days	5/31/08	
15. Claim Department Goals	Meet or exceed - • Cut & inquiries within 2 weeks • Develop track/trend process for claim inquiries • Develop denial process for claim reconsiderations • Claim queues < 30 days • Validation < 10 days	3/31/08	
16. Staffing	• Begin training Analyst II in claims queues – opportunity for 1 Sr. advancement • Begin training Juanita on inventory reports/Batch Mgr quality review – opportunity for 1 Clerk II advancement	6/30/08 2/28/08	
DATA QUALITY			
17. NPI Implementation	• Complete loading of NPI • Develop rendering provider pricing • Staff Training	5/23/08	
18. Operations Guidelines	• Complete KS • Review and update MO for Insure MO differences	2/28/08 5/31/08	
19. Non Par Providers	• Build Benefit Adjudication Rules to support non-par denials w/o authorization (Insure MO)	3/15/08	
20. MO Fee Schedule	• Evaluate and simplify current MO fee schedules/benefit set up	12/31/08	
COMPLIANCE			

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
21. Complete Mandatory Annual Compliance Training	- Develop training materials - Conduct training throughout month of February and early March - Conduct training with Wichita staff once new office is open	3/15/2008	
22. Hire FT Admin Asst for Compliance Department	Hiring process being conducted by Chad Moore	3/1/08	
23. Transition Policy and Procedure process from Admin/BR to Compliance department	Once new AA is hired, work with Betty Reed to incorporate policy and procedure process to the compliance department	End of 1st Q	
24. Create Policy and Procedure database for tracking and monitoring.	- Develop new database for tracking CMFHP Policy and Procedures - Create notification process so that Compliance Department can work proactively to notify managers about upcoming Policy reviews.	5/1/08	
PROVIDER RELATIONS			
25. Cactus	- Current version - Enhancements for different line of business - training of staff on capabilities - Reporting capabilities	3/01/08	
26. Credentialing	- Hire additional staff - Training on NCQA criteria as well as full implementation of standards as applicable to our business - Process improvements for credentialing process - Document processes	3/01/08 5/01/08 9/01/08	
27. SalesLogix	Staff training and full implementation	4/1/08	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
	• Report development	5/01/08	
28. NPI Implementation	• PWF for Project manager • Hire staff • Full implementation	1/01/08 3/01/08 5/31/08	
29. Policies and Procedures	• Review and update as needed	9/01/08	
30. Insure Missouri	• Develop provider education materials	3/01/08	
	• Provider training meetings	4/01/08	
	• Review Network needs for contracting	3/01/08	
31. Healthy Choices	• Develop contract amendments • Network expansion for Region 3 • Develop provider education materials • Provider training meetings		
32. Significant Provider Renegotiations/contract changes	• Truman • Springfield Cox/St. John's		
33. Pay for Performance Implementation / Opportunities	• Investigate programs • Look at programs • How to use existing reports to incorporate into this program , ie Managed Care.com		
CUSTOMER RELATIONS			
Community Relations			
34. Implement SalesLogix CRM to track CR activities	1. Train staff 2. Work on reports	6/1/08	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
35. Review and update all marketing material for CR, CS and HS, including changing the MC+ logos to MO HealthNet	Work with Health Writer to review all communication materials	7/1/08	
36. Produce Audio CD's for marketing outreach and for the website	1. Record Audios 2. Copy 3. Distribute	08/01/08	
37. Maintain a relationship with the CMH marketing group and team up on events	1. Attend meetings 2. Look at group events	On Going	
38. Continue sponsorship of key events and outreach within both states	1. Back to School Rally with Councilman Riley 2. Various back to school Rallies in Ks. & Mo. 3. Free Swim Nights in KCMO (Summer) 4. Healthy Kids Day at the Zoo.	On Going	
39. Continue Hispanic Community Outreach	1. Cinco de Mayo 2. Fiesta Hispania	On Going	
40. Continue to work with Oral Health Kansas and Bridgeport to improve education on good dental hygiene. Assist Bridgeport in implementation of the Smile Central program	1. Purchase tooth brushes as give aways 2. Work with Oral Health Kansas 3. Help with Smile Central roll out	On Going	
41. Work with Taira on advertising opportunities and sponsorship of community events	Work with Media buyer based on need and opportunities.	On Going	
42. Expand the scope of materials to assist the		On Going	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
Health Improvement team and attend collaborative events			
43. Develop marketing materials for Insure Missouri	1. Mandatory language for handbook 2. Brochures 3. ID cards 4. Directory	11/1/08	
Community Relations Missouri			
44. Continue Food Power and Food Power Young Adventure sponsorship and evaluate feedback from parents	1. Order water bottles and keep stock maintained 2. Review surveys	On Going	
45. Look at events in the expansion counties and to reach out to the potential Insure Missouri participants	1. Look at outreach events	On Going	
Community Relations and Provider Relations - Kansas and Missouri			
46. Work in conjunction with PR on the Provider of the Quarter Award and the Above and Beyond Award	1. Develop above and beyond thank you 2. After PR has ID'ed the provider of the quarter, assist in award presentation	09/01/08	
47. Look at opportunities to team up with PR for a provider marketing program	1. Work with media buyer on events such as nurses and doctors day 2. Purchase items for provider offices	On Going	
Customer Service - Kansas and Missouri			
48. Provide education/Hot Topics on inbound member	1. Continue hot topics and request ideas from departments	On Going	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
calls			
49. Review staffing to maintain appropriate call stats are met for current members as well as Insure Missouri and Kansas Health Choices	1. Current staffing adequate. Will review any opportunities needed for Ks. Health Choices based on membership	On Going	
50. Maintain phone stats per goal	1. ASA < 30 seconds 2. Abandonment rate 5% or less	On Going	
51. Reduce or automate member reports to streamline work flow process for increased efficiencies, including a PCP look up tool	1. Review PCP assignment process 2. Review reports with IT	12/31/08	
52. Continue to review work flow to improve and streamline processes		12/31/08	
53. Implement a process to electronically submit eligibility changes in Kansas and Missouri (Newborns, address/phone changes)	1. Work with the states on this process	12/31/08	
54. Roll out and improve the CS training manual that will be accessible to all employees	1. Roll out manual to all staff 2. Make manual accessible via internet 3. Update as needed.	3/31/08	
55. Work with the state to obtain disenrollment data and annually review	1. Review disenrollment reports	On Going	
56. Review welcome call and adult nurse line program and determine effectiveness of survey,	1. Obtain 2007 results and determine reach rate from survey 2. Reword the survey tool 3. Review options of other vendors if	6/30/08	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
member feedback and review options of improved process or vendor for the survey distribution	needed		
57. Continue working with the CAC for Kansas and Missouri and follow up on feedback. Encourage participation by community advocates.	1. Quarterly meetings set for Topeka, KC and Wichita. 2. Explore option of CAC in expansion counties	Quarterly	
58. Implement Insure Missouri program and work on development of member materials. Respond to RFP and begin working on enrolling Kansas Healthy Choice members for 2009.	1. Order member materials 2. Work with Mail house on mailings 3. Educate staff 4. Respond to RFP for Ks. 5. Begin implementations	3/1/08 for Insure Mo and TBD for RFP and Ks. Health Choices	
59. Review MTM's current contract and finalize contract and reconciliation	1. Review utilization. 2. Review pricing proposal 3. Make language changes	4/1/08	
Community Relations and Customer Service			
60. Look for direction from EDS on the implementation of the Advanced ID cards and look at opportunities to avoid duplication	1. Meet with EDS on their roll out 2. Work on possible duplication of cards with state.	09/01/08	
61. Attend State Consumer Advisory Committees in Jeff City	Quarterly	Quarterly	
62. Work on development of program to obtain feedback from members in follow up to encounters	1. Work with CS to follow up with members to see how their experience was with CMFHP	7/1/08	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
63. Work on move to Crown Center and work area requirements		11/1/08	
Customer Relations and IT-Kansas and Missouri			
64. Explore pod casting and other communication vehicles to improve communication via the Internet	1. Work with IT to see if this is possible. 2. Develop process	10/31/08	
65. Assist in redesigning and updating the Internet web site to be more member and provider friendly	1. Health Writer will work with IT on the design.	10/31/08	
66. Look at options of using the web site as a communication tool to provide such things as automated ID card request, address, phone and PCP changes that are linked to iBenefits	1. Work with IT on automation	10/31/08	
67. Look at customizing the ACD reports	1. Steve to review options to improve reports	10/31/08	
Government And Public Affairs			
68. Missouri – Insure Missouri/Mo HealthNet	Monitor legislative activity. Maintain message: managed care saves money	1-2 Quarters	
69. Public Affairs	Work with Health Services to get media coverage of programs such as our obesity program for children.	Ongoing	
70. Internal Communication	Find a way to communicate the ,,day in the life' of employees and telling the story of how the are affecting member lives	2nd Quarter	
71. PAC	Form, fund and facilitate the start-up of this	2nd Quarter	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
	organization		
HEALTH SERVICES - General			
72. Implement Documentation in CARE **(Ma'ata)**	a. Assist in the development of process for Health Coaches, Lead Care Managers, and Outreach Coordinators.	2nd Q 2008	
(Ma'ata)	b. Schedule training	3rd Q 2008	
73. Participate in Medical Home Project at CMH (Ma'ata)	a. Participate in routine board meetings	Ongoing	
(Ma'ata)	b. Provide updates to management team at CMFHP	Ongoing	
86. Develop Medical Home concept and workplan (TBD)	a. Implement Medical Home Workgroup	2nd Q 2008	
Clinical Services			
74. Ensure available resources for clinical staff (Christy/Sally)	a. Create new Clinical Services binder for new employee orientation, incorporating KS information	4th Q 2008	
(Sally)	b. Establish process for maintaining benefit grid	1st Q 2008	
(Jenny)	c. Cleanup and reorganize all online HS/UM/QM/HI folders	4th Q 2008	
75. Expand ER Care Management program (Lisa)	a. Complete cross-training of ER Care Manager	1st Q 2008	
(Lisa)	b. Implement ER task force to develop action plan for expansion of ER program	1st Q 2008	
(Christy)	c. Identify targeted facilities	1st Q 2008	
(Christy)	d. Partner with PR for provider visits	2nd Q 2008	
(Christy)	e. Meet with key stakeholders at identified facilities	2nd Q 2008	
(Christy)	f. Implement ER program at identified facilities	2nd Q 2008	
(Lisa)	g. Transition CMH ER program to designated position	1st Q 2008	
76. Implement Health Literacy Program **(Lisa)**	a. Train 4 identified staff on how to teach the program in small groups	1st Q 2008	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
(Christy)	b. Identify appropriate venues for teaching the program – meet with CR	2nd Q 2008	
(Christy)	c. Develop tracking tool for data collection and outcomes	2nd Q 2008	
(Christy)	d. Conduct at least 4 trainings in 2008	4th Q 2008	
77. Enhance Care Management Programs **(Christy)**	a. Develop library of resources for OB member education and health literacy	3rd Q 2008	
(Christy)	b. Explore expanding cell phone program to behavioral health members with New Directions	2nd Q 2008	
(Christy)	c. Develop OB Care Manager role and expectations in Wichita and begin hiring process	2nd Q 2008	
(Jenny)	d. Identify PNF database changes needed for compliance with HEDIS collection	2nd Q 2008	
(Jenny)	e. Implement PNF database changes as identified	3rd Q 2008	
78. Establish ongoing outcome measurements for existing programs **(Ma'ata)**	a. Develop and complete premie analysis from PNF database	2nd Q 2008	
(Ma'ata)	b. Develop and complete analysis process for Snugli incentive program	3rd Q 2008	
(Ma'ata)	c. Develop ongoing analysis plan for ER Care Management programs in MO and KS	2nd Q 2008	
(Ma'ata)	d. Develop data analysis plan for health literacy program	4th Q 2008	
(Ma'ata)	e. Develop data analysis plan for Oxford telemonitoring program	2nd Q 2008	
Health Improvement			
79. Achieve Joint Commission re-certification for the Asthma Management Program **(Greg)**	a. Submit application	1st Q 2008	
(Greg)	b. Update policies	1st Q 2008	
(Greg)	c. Assemble Documentation	1st Q 2008	
(Greg)	d. Complete Review	2nd Q 2008	
80. Evaluate feasibility of implementing diabetes DM program	a. Review data to find prevalence of diabetes in member population	2nd Q 2008	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
(Greg)			
(Greg)	b. Identify a physician champion for diabetes DM program	3rd Q 2008	
(Greg)	c. Hire FTE for diabetes program Health Coach	4th Q 2008	
(Greg)	d. Develop diabetes program components	4th Q 2008	
81. Enhance member and provider outreach **(Greg)**	a. Develop internet provider education modules.	3rd Q 2008	
(Greg)	b. Develop HI Web page	3rd Q 2008	
(Greg)	c. Develop web resources for members and providers.	3rd Q 2008	
(Greg)	d. Explore additional strategies for communicating with members and providers.	4th Q 2008	
(Greg)	e. Develop and implement quarterly DM member newsletters	3rd Q 2008	
(Greg)	f. Develop process to coordinate mailings, newsletter articles, on-hold messages and national health-related awareness events.	2nd Q 2008	
(Greg)	g. Evaluate use of Sales Logic for tracking provider education and visits	2nd Q 2008	
82. Refine Employee wellness program **(Greg)**	a. Implement Wellness Committee	1st Q 2008	
(Greg)	b. Evaluate Phase I program results.	4th Q 2008	
(Greg)	c. Determine level of ongoing involvement by HI staff	4th Q 2008	
(Greg)	d. Determine Phase II program priorities	4th Q 2008	
83. Expand current DM programs (Greg)	a. Develop and implement IRR for Health Coaches	2nd Q 2008	
(Greg)	b. Hire staff to expand in KC, Wichita, and Topeka	3rd Q 2008	
84. Implement collaboration with dental programs in MO and KS **(Greg)**	a. Implement cooperative for presenting modules in offices with KDHE dental program	1st Q 2008	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
(Greg)	b. Meet with dental vendors in both states to identify opportunities for collaboration	2nd Q 2008	
(Greg)	c. Explore AAP's "Bright Smiles" program for potential collaboration	2nd Q 2008	
Quality Management			
85. Enhance the PCP MRR tool with IT for valid and reliable PCP identification through MC400 (Jenny)	a. Meet with IT for coordination of enhancing PCP Medical Record Review Tool	1st Q 2008	
(Jenny)	b. Coordinate with IT to beta test updates	4th Q 2008	
86. Complete HEDIS medical record reviews in KS and MO (Jenny)	a. Follow HEDIS workplan and complete reviews to report all by contract deadlines	2nd Q 2008	
87. Complete member satisfaction surveys in MO & KS **(Jenny)**	a. Follow workplan and complete surveys and reporting to report all by contract deadlines	3rd Q 2008	
(Jenny)	b. Prepare analysis of the CAHPS process and outcomes	3rd Q 2008	
88. Implement scanning options for QM documents **(Jenny)**	a. Meet with IT for discussion of the HEDIS documents to be scanned	1st Q 2008	
(Jenny)	b. Meet with IT for discussion of the appeal process document scan	1st Q 2008	
(Jenny)	c. Evaluate with IT the scanning options for QM documents	2nd Q 2008	
(Jenny)	d. Implement scanning of QM documents deemed feasible	4th Q 2008	
89. Enhance appeal databases for both KS and MO to include medical director documentation (Jenny)	a. Coordinate with IT to develop review form	1st Q 2008	
(Jenny)	b. Assist in the development of CARE to include CGA reviews	2nd Q2008	
(Jenny)	c. Coordinate with IT for beta testing of the review form	3rd Q 2008	
90. Develop process for	a. Develop minimum requirements for delegated	3rd Q 2008	

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
delegated entities to have PCP MRR exemption **(Jenny)**	entities PCP MRR exemption		
(Jenny)	b. Write process for CMFHP to solicit delegated entities for the process by which they perform MRR for quality audit processes. Will include steps for CMFHP review of the written process and auditing the delegated entity and communication of process outcomes	3rd Q 2008	
(Jenny)	c. Meet with Provider Relations to formulate next steps, which may include discussion with high volume delegated entities in both Missouri and Kansas	3rd Q 2008	
(Jenny)	d. Present process to QMC	4th Q 2008	
(Jenny)	e. Implement process	4th Q2008	
91. Complete update of letters for appeal processes **(Jenny)**	a. Coordinate with IT and Compliance Manager for requested formatting updates to all appeal letters	3rd Q2008	
FINANCE			
92. Validate Encounters Submitted to Missouri	a. reconcile going forward encounters filed and accepted by Missouri HealthNet and cost reported on Attachment 10 b. request reports necessary for this process and and validate the reports c. identify encounters not submitted and document amounts and cause/ reason d. identify encounters rejected and not reworked and submitted successfully e. continue to meet monthly with State on task force to communicate state system issues identified as causing reconciling differences f. continue internal task force meeting to communicate and correct internal system issues identified as causing reconciling differences.	4th Q 2008	

Attachment 18

Children's Mercy Family Health Partners
2008 QI Workplan

GOAL	ACTIONS	TARGET DATE	SUMMARY
93. Support Analysis of New Lines of Business	a. Incorporate, Expansion County, Insure Mo and KS Healthy Choice into analysis b. Provide support for KS Healthy pricing bid	2rd Q2008	
94. IRS Registration for 1099 TIN match	a. Register with IRS so can do TIN matches through IRS resources.	4th Q 2008	
95. Automate Month-End Close Reports (claims based)	a. Automate the following claim based reports: ▪ Lag creation, including encounter data ▪ Claims Detail download matching lag ▪ Reinsurance reporting ▪ Vendor Top 50. M-1 Schedules ▪ Summary of encounters submitted for carve-out providers including utilization and cost indicators necessary for Att10 & DOI reporting and tracking contract performance	4th Q 2008	
96. Automate Month-End Close Reports (GL based)	a. Automate the following accounting reports from the GL system ▪ CMH FY Income Statement/Budget ▪ All Staff Report ▪ In the Know Report	2nd Q 2008	
97. Review Internal Accounting Controls	a. Review and document assessment of internal accounting control b. Make modifications as necessary	2th Q 2008	
98. Increase value of MC.COM	c. Create standard AOC package d. Increase contact/set up routine or quarterly calls with MC.COM e. Obtain better understanding of other Dept. usage f. Educate other department of tools available not being used.	4th Q 2008	
99. Standard Provider Reporting	a. Semi-annual profile reporting for KS and MO b. Standard package for Provider Reps to enhance Provider Support, designed to monitor reimbursement and utilization	3rd Q 2008	

17

Harmony Health Plan IL, IN, MO
Quality Improvement and Utilization Management Work Plan 2008

Task Name
1 Health Services Goals/Objectives - 2008 - 2009
2 Quality Goals/Objectives - 2008 - 2009
3 HFS 2008 Quality With-Hold Targets 7 of 8, Stretch 8 of 8
4
5 Childhood Immunizations - Combo 2
6 Well Child Visits - 0-15 Months
7 Well Child Visits - 3-6 YOA
8 Breast Cancer Screening
9 Cervical Cancer Screening
10 Timeliness of Prenatal Care
11 Asthma
12 Diabetes Mellitus - HgbA1C
13 Statistically Significant HEDIS Results
14 Goals - IMD HEDIS Statistically Significant - Target 33% (Net), Stretch 50%
15 Goals - IMR HEDIS Statistically Significant - Target 33% (Net), Stretch 50%
16 Goals - MMD HEDIS Statistically Signficant - Baseline Year
17 Goals - PFQ +10% year over year Quality Compass Target 150% improvement, Stretch 200%
18 Utilization Management Goals/Objectives - 2008 - 2009
19 Goals - Utilization Management Trending
20 Goals - UM IMD Target <1.25% increase, Stretch Flat
21 Goals - UM IMR Target <3% increase, Stretch Flat
22 Goals - UM MMD Target <7.5% increase, Stretch Flat
23 Goals - UM Readmission Rates - Target Flat, Stretch <3% increase
24 Goals - UM - HUGS Target >80% Participation, Stretch >90% Participation
25 Goals - CM - ER Outreach Target <10%, Stretch <15%
26 Administrative Goals - 2008 - 2009
27 Execution - 2008 - 2009
28 Goals - Retain bench strength by reducing Associate Turnover - Target <20%, Stretch <10%
29 Goals - Measure/Report education and outreach efforts - Monthly Field Database Reporting (by Health Services FTE) Target Weekly, Stretch Daily
30 Goals - Provider Visit Schedule by Month/RN/SW (PENDING review of PR Database r/t volume/provider/IPA)
31 Goals - Visit Physician Groups to reinforce PFQ CAP - Status (Quarterly, Stretch 6/year)
32 Goals - Redefine HEDIS Chart Abstraction Process
33 Goals - Define Cost Benefit of internal vs external Chart Abstractions (External 2009 - $471,798 (Including 10% assumption on increase in membership)
34 Goals - Create HUGS Work Plan (Below)
35 Goals - Quality Push 2008 (Pending 2008 Noncompliant CRMS data)
36 Goals - Research/Repair Encounter Issues (following HEDIS June 2008 and release of 2009 data)
37 Goals - Investigate/implement utilization of CRMS Provider Report Cards
38 Goals - Health Services Policy & Procedure Review

39 Goals - Modify Quality Encounter Database, update P & P's, Work Flow and IRR

40 Field Activities - Quality Improvement - Member and Provider Education (Reported in Team Field Activity Database)

41 Quality - Education/Outreach - Provider

42 Provider Education/Outreach Meetings Cook West/North Target - 8/Week, Stretch 10/Week

43 Provider Education/Outreach Meetings Cook East/South Target - 8/Week, Stretch 10/Week

44 Provider Education/Outreach Meetings Southern Target - Target - 6/Week, Stretch 8/Week

45 Provider Education/Outreach Meetings Missouri Target - 6/Week, Stretch 8/Week

46 Quality - Education/Outreach Meetings - IPA - Target - Quarterly, Stretch 3/Month

47 Quality - Education/Outreach Meetings - HHPI Associates Target - Quarterly, Stretch 1/Month 48 Reporting - Team Field Activity Database Completion Target - Weekly, Stretch Daily, Report monthly

49 Provider HHPI Newsletters Target - 1/year, Stretch 2/year

50 Provider Health Services Newsletters Target - 2/year, Stretch Quarterly

51 Quality - Education/Outreach - Member

52 Member Health Fairs Target - 1/Quarter, Stretch 6/Year

53 Member Community Centers Target - 1/Quarter, Stretch 6/Year

54 Member Parent Teacher Conferences/Report Card Days Target - 2/Year, Stretch Quarterly

55 Member Healthy Kids Club Target - Target - 1/Quarter, Stretch 6/Year

56 Member Baby Showers Target - 1/Quarter, Stretch 6/Year

57 Member Religious Venues Target - Target - 1/Quarter, Stretch 6/Year

58 Member Periodicity Letters Target - 1/Quarter, Stretch N/A

59 Member Newsletters Target - 2/Year, Stretch 1/Quarter

60 Member Telephonic Reminder/Outreach Calls Target - 2/Year, Stretch 1/Quarter

61 Quality - Networking/Improving Relationships

62 Quality - Networking Relationships - State

63 Quality - Networking Relationships - EQRO

64 Quality - Networking Relationships - Provider Visits

65 Quality - Networking Relationships - Member Visits

66 Quality - Networking Relationships - IPA Visits

67 Quality - Networking Relationships - Health Fairs

68 Quality - Networking Relationships - Department of Public Health

69 Quality - Networking Relationships - Advocacy Groups

70 Quality - Networking Relationships - Maternal Child Coalition

71 Quality - Networking Relationships - Amerian Lung Association (Asthma)

72 Quality - Networking Relationships - Public Schools/Head Start Programs

73 Quality - Networking Relationships - American Cancer Society/Y-Me

74 Quality - Networking Relationships - American Diabetic Association

75 Quality - Networking Relationships - Family Case Management/Women Infants Children (FCM/WIC)

76 Quality - Networking Relationships - Mental Health (H-SASS/SASS)

77 Quality - Incentive Programs

78 Provider Pay for Quality (IMD)

79 Well Child Visits 0-15 months

80 Lead Screening

81 Childhood Immunizations (Combo 3)

82 Well Child Visits 3-6 years of age

83 Timeliness of Prenatal Care
84 Postpartum Care
85 Cervical Cancer Screening
86 Breast Cancer Screening
87 Asthma Medication Utilization (combined)
88 Comprehensive Diabetes Care (HbA1C)
89 Provider Pay for Quality (IMR)
90 Comprehensive Diabetes Care
91 HbA1C - Control
92 Retinal Eye Exam
93 LDL-c Control
94 Nephropathy
95 Blood Pressure Control
96 Colorectal Cancer Screening
97 Breast Cancer Screening
98 Glaucoma Screening
99 Osteoporosis Management in Women
100 Provider Pay for Quality (MMD)
101 Well Child Visits 0-15 months
102 Lead Screening
103 Childhood Immunizations (Combo 3)
104 Well Child Visits 3-6 years of age
105 Timeliness of Prenatal Care
106 Postpartum Care
107 Cervical Cancer Screening
108 Breast Cancer Screening
109 Asthma Medication Utilization (combined)
110 Adolescent Well Visits 12-21 years of age
111 Provider Pay for Quality (IMD OB)
112 Timeliness of Prenatal Care
113 Frequency of Ongoing Prenatal Care
114 Postpartum Visit
115 Member Pay for Quality (MIP - IMD)
116 Timeliness of Prenatal Care
117 Breast Cancer Screening
118 Childhood Immunizations (Combo 2)
119 Well Child Visits 0-15 months
120 Quality Reporting - PFQ
121 PFQ/HEDIS - Non Compliant Lists - IPA Target - 1/Quarter, Stretch 6/Year
122 PFQ/HEDIS - Non Compliant Lists - Providers > Target - 1/Quarter, Stretch 6/Year
123 PFQ/HEDIS - Non Compliant Lists - Members Telephonic Target - 1/Quarter, Stretch
     6/Year
124 PFQ/HEDIS - Non Compliant Lists - Members Mailing Target - 1/Quarter, Stretch 6/Year
125 PFQ/HEDIS - Non Compliant Lists - Member Periodicity Letters Target - 1/Quarter,
     Stretch N/A
126 Quality Reporting - HEDIS Measures
127 ADOLESCENT WELL CARE VISITS
128 Adolescent Well Visits

129 IMD
130 MMD
131 ADULTS' ACCESS TO PREVENTIVE / AMBULATORY SERVICES
132 AGES 20-44
133 IMD
134 IMR
135 MMD
136 AGES 45-64
137 IMD
138 IMR
139 MMD
140 AGES 65+
141 IMD
142 IMR
143 MMD
144 ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS
      (COMBINED)
145 ACE Inhibitors or ARBs
146 IMR
147 Anticonvulsants
148 IMR
149 Digoxin
150 IMR
151 Diuretics
152 IMR
153 ANTI-DEPRESSANT MED. MNGT.
154 OUTPATIENT FOLLOW-UP (FU Visits)
155 IMR
156 MMD
157 84 DAY MEDICATION (Acute Med Trial)
158 IMR
159 MMD
160 180 DAY MEDICATION (Effective Drug Therapy)
161 IMR
162 MMD
163 BETA BLOCKER AFTER AMI
164 IMR
165 MMD
166 CHOLESTEROL MANAGEMENT AFTER CVE
167 LDL-C Testing
168 IMR
169 LDL-C Level <130
170 IMR
171 LDL-C Level <100
172 IMR
173 COLORECTAL CANCER SCREENING
174 Fetal Occult Blood Test (FOBT)
175 IMR

176 Flexible Sigmoidoscopy
177 IMR
178 Double Contrast Barium Enema (DCBE)
179 IMR
180 Colonoscopy
181 IMR
182 Appropriate Screening for CRC (HEDIS Rate)
183 IMR
184 COMPREHENSIVE DIABETES
185 HbA1c Testing
186 IMD
187 IMR
188 MMD
189 Poor HbA1c Control (lower % is better)
190 IMD
191 IMR
192 MMD
193 Good HbA1c Control
194 IMD
195 IMR
196 MMD
197 Eye Exam
198 IMD
199 IMR
200 MMD
201 LDL-C Screening
202 IMD
203 IMR
204 MMD
205 LDL-C Level <130
206 IMD
207 IMR
208 MMD
209 LDL-C Level <100
210 IMD
211 IMR
212 MMD
213 BP Control <130/80
214 IMD
215 IMR
216 MMD
217 BP Control <140/90
218 IMD
219 IMR
220 MMD
221 Nephropathy
222 IMD
223 IMR

224 MMD
225 CONTROLLING HIGH BLOOD PRESSURE
226 Controlling HBP 18-45 Yrs of Age
227 IMD
228 IMR
229 MMD
230 Controlling HBP 46-85 Yrs of Age
231 IMD
232 IMR
233 MMD
234 Controlling HBP - Combined
235 IMD
236 IMR
237 MMD
238 DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY IN RHEUMATOID ARTHRITIS
239 IMR
240 DRUGS TO BE AVOIDED IN THE ELDERLY
241 1 Drug
242 IMR
243 >=2 Drugs
244 IMR
245 FOLLOW-UP AFTER HOSP. FOR MENTAL ILLNESS
246 7 Days After Discharge
247 IMD
248 IMR
249 MMD
250 30 Days After Discharge
251 IMD
252 IMR
253 MMD
254 GLAUCOMA SCREENING IN OLDER ADULTS
255 IMR
256 INITIATION & ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT
257 Initiation of AOD Dependence Treatment
258 IMR
259 Engagement of AOD Dependence Treatment
260 IMR
261 OSTEOPOROSIS MANAGEMENT IN WOMEN
262 PERSISTENCE USE OF BETA BLOCKER AFTER AMI
263 IMR
264 USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
265 IMR
266
267 LEAD TESTING
268 Rate #1: 2 Lead Test (1 by 1yr and 1 by 2 yrs)

269 IMD
270 MMD
271 Rate #2: 1 Lead Test (1 Lead Test by 2 yrs)
272 IMD
273 MMD
274 PRENATAL/PP CARE
275 Timeliness of Prenatal Care
276 IMD
277 MMD
278 Postpartum Care
279 IMD
280 MMD
281 FREQ. OF ONGOING PRENATAL CARE
282 <21%
283 IMD
284 MMD
285 21-40%
286 IMD
287 MMD
288 41-60%
289 IMD
290 MMD
291 61-80%
292 IMD
293 MMD
294 81+%
295 IMD
296 MMD
297
298
299
300 WELLCHILD VISITS IN FIRST 15 MONTHS
301 6 visits
302 IMD
303 MMD
304 5 visits
305 IMD
306 MMD
307 4 visits
308 IMD
309 MMD
310 3 visits
311 IMD
312 MMD
313 2 visits
314 IMD
315 MMD
316 1 visit

317 IMD
318 MMD
319 0 visits
320 IMD
321 MMD
322 WELLCHILD VISITS 3-6 YEARS OLD
323 Well Child Visits 3-6 YOA
324 IMD
325 MMD
326 ASTHMA MEDS
327 ASTHMA MEDS 5-9 YO
328 IMD
329 MMD
330 ASTHMA MEDS 10-17 YO
331 IMD
332 MMD
333 ASTHMA MEDS 18-56 YO
334 IMD
335 MMD
336 ASTHMA COMBINED AGES
337 IMD
338 MMD
339 BREAST CANCER SCREENING
340 Breast Cancer Screening 42-51 Yrs of Age
341 IMD
342 MMD
343 Breast Cancer Screening 52-69 Yrs of Age
344 IMD
345 MMD
346 Breast Cancer Screening - Combined
347 IMD
348 MMD
349 CERVICAL CANCER SCREENING
350 IMD
351 MMD
352 CHILDHOOD IMMUNIZATION
353 DTP (Diptheria, Tetanus, Whooping Cough)
354 IMD
355 MMD
356 IPV (Polio)*
357 IMD
358 MMD
359 MMR (Measles, Mumps, Rubella)
360 IMD
361 MMD
362 HIB (Influenza Type B)
363 IMD
364 MMD

365 HEP (Hepatitis B)
366 IMD
367 MMD
368 VZV (Chicken Pox)
369 IMD
370 MMD
371 Pneumococcal Conjugate
372 IMD
373 MMD
374 Combo 2
375 IMD
376 MMD
377 Combo 3
378 IMD
379 MMD
380 CHILDREN'S AND ADOLESCENTS' ACCESS TO PRIMARY CARE PROVIDERS
381 AGES 12-24 MONTHS
382 IMD
383 MMD
384 AGES 25 MONTHS-6 YEARS
385 IMD
386 MMD
387 AGES 7-11 YEARS
388 IMD
389 MMD
390 AGES 12-19 YEARS
391 IMD
392 MMD
393 CHLAMYDIA SCREENING
394 SCREENING 16-20 YO
395 IMD
396 MMD
397 SCREENING 21-25 YO
398 IMD
399 MMD
400 SCREENING COMBINED
401 IMD
402 MMD
403 TESTING FOR CHILDREN W/PHARYNGITIS
404 MMD
405 TREATMENT FOR UPPER RESP. INFECTION
406 MMD
407 Quality Improvement - Surveys
408 Quality Improvement - Member Satisfaction Surveys (CAHPS) - Target 1/Year
409 IMD
410 IMR
411 MMD
412 Quality Improvement - Provider Satisfaction Surveys - Target 1/Year

413 IMD
414 IMR
415 MMD
416 Quality Improvement - Access & Availability Monitoring - Target 1/Year
417 IMD
418 IMR
419 MMD
420 Quality Improvement - GEO Access - Target 1/Year, Stretch 2/Year
421 IMD
422 IMR
423 MMD
424 HMR
425 Quality Improvement - Harmony Behavioral Health - Target 1/Year, Stretch 2/Year
426 IMD
427 IMR
428 MMD
429 Quality Improvement - Performance Improvement Projects (PIPs - 9)
430 Quality Improvement - PIP/Root Cause Analysis - Asthma (IMD)
431 Pharmacy Data File Loads
432 Pharmacy Script Fills/Refills (Facility and FQHC's)
433 Asthma Adventure Camp
434 Asthma Walk
435 Pay For Quality Programs
436 Quality Improvement - PIP/Root Cause Analysis - Perinatal (IMD)
437 Contracting New - OB's
438 Contracting - WIC/FCM
439 Reporting - Bi-weekly
440 Harmony Hugs
441 Posters
442 UIC Perinatal Program
443 Case Management - Nursing
444 Case Management - Harmony Behavioral Health
445 Pay For Quality Programs
446 Quality Improvement - PIP/Root Cause Analysis - EPSDT (IMD)
447 Provider Outreach/Education
448 Member Outreach/Education
449 Provider Survey
450 Pay For Quality Programs
451 Quality Improvement - PIP - Mental Health (IMD)
452 Analyze Data
453 Identify PIP question
454 Create Timeline
455 Quality Improvement - PIP/Root Cause Analysis - Lead Screening (MMD)
456 Provider Outreach/Education
457 Member Outreach/Education
458 Pay For Quality Programs
459 Quality Improvement - PIP/Root Cause Analysis - AWV/EPSDT (MMD)
460 Provider Outreach/Education

461 Member Outreach/Education
462 Pay For Quality Programs
463 Quality Improvement - PIP - Access to Care (IMR)
464 Provider Outreach/Education
465 Member Outreach/Education
466 Quality Improvement - PIP - HgbA1c - (IMR)
467 Provider Outreach/Education
468 Member Outreach/Education
469 Pay For Quality Programs
470 Quality Improvement - PIP - Medical Record Reviews (IMD/IMR/MMD/INR)
471 Chart Abstraction
472 Scoring
473 Provider Education
474 Rescoring
475 Data Analysis
476 Quality - Administrative/Compliance
477 Audits - EQRO - IMD Target 1/Year, Stretch 2/Year
478 Audits - EQRO - MMD Target 1/Year, Stretch 2/Year
479 Audits - HEDIS (IMD/MMD) Target 1/Year, Stretch 2/Year
480 Quality - Corrective Action Plans
481 CAP - HEDIS Measures
482 CAP - Compliance Audit 2006
483 CAP - Compliance Audit 2008
484 CAP - HEDIS WCV/PPN/Imms
485 CAP - PFQ Status Report - Target Quarterly, Stretch 6/Year
486 HEDIS (IL/IN/MO)
487 HEDIS Bootcamp
488 HEDIS Vendor - Outcomes - Statistical Oversite
489 HEDIS Vendor - Outcomes - Pend Research
490 BAT Submission (IMD, IMR, MMD)
491 Administrative
492 Annual Evaluations/Reports
493 Annual Program Descriptions
494 Annual Work Plans
495 Monthly QI/UM Dashboard (Activities)
496 Quality - Clinical Practice Guidelines and Preventive Health Guidelines
497 Asthma
498 Congestive Heart Failure
499 Diabetes Mellitus
500 Hypertension
501 HIV
502 Immunizations
503 Perinatal
504 Utilization Management
505 Activities
506 Utilization Management - FCM Cluster Work Groups
507 Utilization Management - Pregnant Women
508 Utilization Management - Children

509 Utilization Management - Adults
510 Utilization Management - Case Management
511 Utilization Management - Disease Management
512 Utilization Management - Behavioral Health
513 Utilization Management - HUGS Newsletter
514 Utilization Management - CAT Cases
515 Utilization Management - SSI/AABD
516 Utilization Management - Health Risk Assessments
517 Utilization Management - HUGS
518 Utilization Management - Provider NIPs
519 Case Management - ER Outreach
520 Perinatal Outreach -HUGS
521 Incentive programs - Member
522 Prenatal MIP 1 visit first trimester/42 days of enrollment - Compliant = $25.00 Gift Card
    (IMD)
523 OB Prenatal Reward Program 6 prenatal visits, 1 postpartum visit = stroller
524 OB Prenatal Reward tracking report
525 Incentive programs - Provider
526 OB Incentive - Early Notification = $25.00/member
527 OB Incentive payout log
528 OB PFQ - PPC $25, FPC $100, PPV $25 (upto $150/member)
529 Perinatal PIP
530 Revisions
531 Evaluation of interventions
532 Perinatal Outreach - Hugs
533 EDD Report outreach (IMD)
534 Prenatal Vitamin Report outreach (MMD)
535 New Pregnant MMD Report outreach
536 SIL Pregnant New Applicant Report outreach
537 Referrals from Member Services
538 Member self-referrals
539 OB Notification outreach
540 Health Needs Assessment Forms (HNAF) Outreach
541 HRA Report (IMD) outreach
542 UM Nurse referrals
543 CM Nurse referrals
544 HBH CM referrals
545 FCM referrals (CK)
546 Community agency referrals
547 Educate on OB Prenatal Reward Program using new outreach letter
548 Member Activity - Hugs
549 Initial Hugs Evaluation
550 Home visits
551 Hugs member follow ups
552 New Hugs Packets
553 Post Partum assessment
554 Post Partum Packets-Hugs members
555 Post Partum Outreach letter -all IMD/MMD deliveries

556 SSI Referral Outreach
557 SSI Application assistance w/ member in home
558 SSI Application assistance w/ SSA office
559 Maintain SSI Log for state
560 Database Revision
561 Tracking of Harmony Hugs satisfaction survey
562 Harmony Hugs Data entry
563 Harmony Hugs Newsletter
564 Harmony Hugs Poster
565 Logging and ordering of Hugs education mterials
566 Hugs Member Education Baby Showers
567 HHP Hugs website
568 Re-Organization of HNAF
569 Community Outreach - Hugs
570 Community Agency Outreach and Coordination
571 Educational workshops for community agencies
572 Educational Programs
573 Participation in community events
574 Participation in Harmony sponsored community events
575 Pregnancy Prevention Education with schools
576 FCM Cluster Meetings (CK)
577 Consumer Advisory Committee educational sessions
578 Provider Outreach - Hugs
579 Provider Education mailings
580 Provider Visits
581 Provider training opportunities
582 Participate in provider office Baby Shower events (MMD)
583 Field Activity Log data entry
584 Trainings - Hugs
585 In-service for CM team - Coordination with Hugs
586 *implementation of timely referral process
587 In-service for UM Concurrent Review Nurse team - Coordination with Hugs
588 *implementation of timely referral process
589 In-service for ALL marketing/sales team reps - Hugs updates
590 In-service for HBH - Coordination with Hugs
591 In-service for level II member service reps - Coordination with Hugs
592 In-service for member services team - Hugs updates
593 HHPI Meetings - Hugs
594 Generate Harmony Hugs monthly reports / continue making modifications to improve
    reporting
595 Customer Service Quality Imrpovement Workgroup (CSQIW) IL/MO
596 IL Medical Advisory Committee (IL MAC)
597 MO Medical Advisory Committee (MO MAC)
598 Quality Improvement Committee (QIC)
599 Health Services Team Meeting
600 Consumer Advisory Committee
601 OB Efforts Workgroup
602 State Activites - Hugs

603 Illinois Maternal Child Health Coalition-Chicago Area Meeting
604 IMCHC- Campaign to Save Our Babies
605 Illinois Maternal Child Health Coalition-SIL Area Meeting
606 St. Louis Maternal Child and Family Health Coalition
607 HFS/HSAG All Plan Meeting
608 MC+ Managed Care Quality Assessment and Improvement Advisory Group
609 MO Maternal Child Health Task Force
610 Health Services Team Special Projects
611 **assist team as needed
612 Corporate/Local and Adhoc Committees
613 Committee - Board of Directors (BOD)
614 Committee - Board of Directors (BOD) - QIC Agenda/Minutes to BOD
615 Committee - Board of Directors (BOD) - Agenda/Minutes for QIC
616 Committee - Quality Improvement (QIC) (Minutes 1 week prior to actual meeting)
617 Committee - Quality Improvement (QIC) Agenda/Minutes/Action Register
618 Committee - Credentialing Agenda/Minutes
619 Reporting - Credentialing
620 Reporting - Recredentialing
621 Committee - Medical Advisory (MAC) Agenda/Minutes
622 Reporting - MAC
623 Reporting - HBH
624 Reporting - Quality Management
625 Reporting - Utilization Management
626 Reporting - Appeals
627 Reporting - Grievance
628 Reporting - Compliance
629 Reporting - Provider Relations
630 Reporting - Operations
631 Reporting - Marketing
632 Committee - Credentialing/Recredentialing
633 Committee - Credentialing/Recredentialing Agenda/Minutes/Action Register
634 Reporting - Credentialing
635 Reporting - Recredentialing
636 Reporting - In Que
637 Reporting - Leveling Review
638 Reporting - QOC/QOS Impact
639 Reporting - Utilization Management
640 Committee - Medical Advisory Committee (IL/IN/MO)
641 Committee - MAC Agenda/Minutes/Action Register
642 Reporting - HBH
643 Reporting - Quality Management
644 Reporting - Utilization Management
645 Reporting - Appeals
646 Reporting - Grievance
647 Reporting - Compliance
648 Reporting - Provider Relations
649 Reporting - Operations
650 Reporting - Marketing

651 Committee - Delegation Oversite (DOC)
652 Delegation Oversite (DOC) - Minutes/Agenda/Action Register
653 Delegation Oversite (DOC) - Audits
654 Delegation Oversite (DOC) - Tool
655 Delegation Oversite (DOC) - CAP/Templates
656 Delegation Oversite (DOC) - CAP Removal
657 Delegation Oversite (DOC) - Group Reports
658 Committee - Appeals & Grievances
659 Appeals/Grievances - Minutes/Agenda/Action Register
660 Reporting/Discussion Appeals
661 Reporting/Discussion Grievances
662 Reporting/Discussion Member Participation
663 Committee - Pharmacy & Therapeutics
664 Pharmacy & Therapeutics - Minutes/Agenda/Action Register
665 Reporting/Discussion - P & T
666 Committee - QI Interventions Work Group
667 QI Intervention Work Group - Minutes/Agenda/Action Register
668 Reporting/Discussion - Activities/Deliverables
669 Committee - Customer Service Quality Improvement Work Group (CSQIW)
670 Committee - CSQIW Agenda/Minutes/Action Register
671 Reporting - HBH
672 Reporting - Quality Management
673 Reporting - Utilization Management
674 Reporting - Appeals
675 Reporting - Grievance
676 Reporting - Compliance
677 Reporting - Provider Relations
678 Reporting - Operations
679 Reporting - Marketing
680 Committee - Utilization Management Review Work Group
681 Committee -UMWG Agenda/Minutes/Action Register
682 Reporting - HBH
683 Reporting - Utilization Management
684 Reporting - Appeals
685 Reporting - Grievance
686 Committee - Consumer Advisory Work Group
687 Committee -CAWG Agenda/Minutes/Action Register
688 Surveys
689 Questionaires
690 Grievances
691 Committee - Utilization Management Census Review
692 Review Daily Inpatient Census against Interqual Criteria
693 Identify cases for Physician Advisor Review
694 Identify cases for readmission
695 Refer inpatient admissions to Case Management
696 Refer inpatient admissions to HUGS
697 Committee - Corporate Encounter Data Work Group
698 Minutes/Agenda/Action Register

699 Reporting/Discussion
700 Committee - Corporate Compliance (P & P's)
701 Review of current P & P's
702 Review of Updated P & P's
703 Review of New P & P's
704 Committee - HEDIS Work Group Agenda/Minutes
705 Review of HEDIS Timelines
706 Review of Baseline Assessment Tool
707 Audit Preparation
708 Review of System Upgrades
709 Reporting
710 Reporting
711 Reporting - Practice/Preventive Health Guidelines
712 Reporting - Peer Review (QOC/QOS cases)
713 Reporting - Risk management
714 Reporting - Pharmacy
715 Reporting - Case/Disease Management
716 Reporting - Utilization Management (Days, Over/Under, ER)
717 Reporting - Delegated Entities
718 Reporting - Regulatory
719 Reporting - State/EQRO Agencies
720 Reporting - Annual Report - IL
721 Reporting - Annual Report - MO
722 Behavioral/Mental Health
723 Harmony Behavioral Health - QIC Agenda/Minutes
724 Harmony Behavioral Health - Utilization Management
725 Harmony Behavioral Health - Program Evaluation
726 Harmony Behavioral Health - Program Description
727 Harmony Behavioral Health - Program Work Plan
728 Harmony Behavioral Health - Performance Improvement Projects
729 Harmony Behavioral Health - Appeals & Grievances
730 Harmony Behavioral Health - Provider Relations/Network Development
731 Harmony Behavioral Health - Credentialing Summary
732 Provider Relations
733 Provider Relations - Dashboard
734 Provider Relations - Contracting/Network Expansion
735 Provider Relations - Credentialing
736 Provider Relations - Provider Manual (IMD)
737 Provider Relations - Provider Manual (IMR)
738 Provider Relations - Provider Manual (MMD)
739 Provider Relations - Provider Manual (INR)
740 Provider Relations - Provider Directory (IMD)
741 Provider Relations - Provider Directory (IMR)
742 Provider Relations - Provider Directory (MMD)
743 Provider Relations - Provider Directory (INR)
744 Provider Relations - GEO Access (IMD)
745 Provider Relations - GEO Access (IMR)
746 Provider Relations - GEO Access (MMD)

747 Provider Relations - GEO Access (INR)
748 Provider Relations - Access and Availability (IMD)
749 Provider Relations - Access and Availability (IMR)
750 Provider Relations - Access and Availability (MMD)
751 Provider Relations - Access and Availability (INR)
752 Provider Relations - Provider Satisfaction Survey (IMD)
753 Provider Relations - Provider Satisfaction Survey (IMR)
754 Provider Relations - Provider Satisfaction Survey (MMD)
755 Provider Relations - Provider Satisfaction Survey (INR)
756 Network
757 Contracting - OB's
758 Contracting - WIC/FCM
759 Operations
760 Operations - Work Group Agenda/Minutes
761 Operations - Enrollment
762 Operations - Appeals
763 Operations - Grievances
764 Operations - Member Service
765 Operations - Provider Service
766 Encounter Data Management
767 Encounter/Claims Data
768 Encounter Data - Electronic
769 Encounter Data - Paper
770 Encounter Data - Research/Resolution
771 Encounter Data - Monthly Intake/Output
772 Encounter Data - CRMS
773 Encounter Data - PFQ

HealthCare USA
Work Plan for Calendar Year 2009

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Program Structure					
Quality Management (QI/UM) Committee Charter (Regulatory)	Annual Update/revision to QMC Charter.	QMC Approval needed	Director, QI	Sep 2009	Annually
Quality Management (QI/UM) Strategy (Regulatory)	Annual Update/revision to QI Strategy.	QMC Approval needed	Director, QI	Sep 2009	Annually
Credentialing Plan/Program Description (Regulatory)	Annual update/revision to Credentialing plan/program description.	QMC and Credentialing Committee Approval needed	Director, Provider Relations	June 2009	Annually
Annual QM (QI/UM) Work Plan (Regulatory)	Annual update/revision to QI/UM Work plan.	QMC Approval needed	Director, QI	Sep 2009	Annually
Annual (QI/UM) Program Evaluation (Regulatory)	Annual written evaluation of QI/UM program outcomes.	QMC Presentation	Director, QI	Nov 2009	Annually
Annual Subcontractor Evaluation (Regulatory)	Annual written evaluation of subcontractors' performance.	QMC Presentation	Manager Regulatory Compliance	Nov 2009	Annually
Quality Improvement (QI/UM)Policies and Procedures	Annual review of QI policies and procedures.	QMC Presentation	Director, QI	Sep 2009	Annually

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
(Regulatory)					

Quality Improvement Activities/Performance Improvement Projects (PIPs)

Clinical PIPs	AIM	Approval/Review	Dept/Person	Due to QMC	Frequency
Emergency Department Over Utilization (clinical outcomes, safety and costs)	Decrease non-emergent/avoidable ED Utilization as evidenced by Improved ED HEDIS rate.	QMC Approval: 10/24/07 Start: 10/24/07 Other Links: DM Task Forces;	Director, QI	Mar 2009 and PRN	Quarterly
BIB Prenatal Program (clinical outcomes)	Increase adherence to prenatal and post partum care consistent with the ACOG CPG, as evidenced by improvement in HEDIS timeliness of prenatal care and HEDIS post partum rate	QMC Approval: Nov. 2006 Start: Jan. 2007 Other links: Med Mgt., OB Task Force (High Risk OB DM); HEDIS/EPSDT Team	Director, QI	March 2009 and PRN	Annually
Obesity (clinical outcomes)	Increase identification and care of members who are obese or at risk of obesity (BMI 95% or greater) consistent with the AAP and AMA CPG as evidenced by an increase in members diagnosed (278.00 and 278.01) and claims for nutritional therapy (97802-97804).	QMC Approval: 2004 Start: 2005; revised in 2008 Other Links: PAC	Director, QI	March 2009 and PRN	Quarterly

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Chlamydia Testing (clinical outcomes; safety r/t complications associated with pregnancy and chlamydia)	Increase adherence to Chlamydia testing per CDC USPST CPG as evidenced by increase in HEDIS rates for chlamydia screening.	QMC Approval: May 2006 Start: 2006 End: Dec 2009 Other Links: HEDIS/EPSDT Team	Director, QI	July 2009 and retire	Annually
Adolescent Well-Care (clinical outcomes)	Improve adherence to AAP CPG for adolescent well care, as evidenced by in increase in the HEDIS rate for adolescent well-care visits.	QMC Approval: Start: Jan. 2007 Other Links: Statewide QA& I Committee PIP; HEDIS/EPSDT Team	Director, QI	July 2009 and PRN	Annually
Hospital Readmissions (clinical outcomes; cost avoidance; safety)	Reduce unscheduled, avoidable hospital readmissions as evidenced by a decrease in the 7 day, 30 day and 90 day readmission rates/1000 and a decrease in the multi-admit rate / 1000 and days/1000.	QMC Approval; Jan 2008 Start: March, 2008 Other Links: Corp Multi-admit process; Med. Mgt.; Disease management Task Forces and project teams	Director, QI	July 2009 and PRN	Annually
Postpartum Depression (clinical outcomes; coordination of care across settings)	Increase the number of members identified with PPD and referred for treatment, as evidenced by an increase in PPD referrals from 7 in 2007, to closer to the national and state PPD rates of 10-12% of deliveries identified with PPD.	QMC Approval: Dec 2008 Start: convert pilot study to a PIP Dec 2008 Other Links: MHNet Coordination of care; Med Mgt.	Director, QI	Jan 2009 and PRN	Annually

Attachment 20

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Synagis (Clinical Outcomes; cost avoidance)	New PIP in September 2008 designed to proactively identify members who may meet criteria and to follow outcomes of Synagis.	QMC Approval: Sep 2008 Start: Sep 2008 Other Links: Med Mgt	Director, QI	Jan 2009 and PRN	Annually
Non-Clinical PIPs					
Denial/IRR Variation (Cost; Regulatory Compliance)	Reduce variation in denial rates and improve inter-rater reliability as evidenced by decreased variation in monthly denial rate by categories report and improve review of outcomes of IRR record reviews	QMC Approval: Dec 2008 Start: Dec. 2008 Other Links: Med. Mgt	Director, QI	Sept 2009	Annually
Grievances & Appeals (Satisfaction; Regulatory Compliance)	Improve timeliness and decrease the volume of grievances and overturns to at or below corp. goals as evidenced by G& A reports.	QMC Approval: Nov 2006 Start: Jan 2007 Other Links: Corp. G& A project;	Director, Appeals and Grievances	March 2009 and PRN	Annually
Encounter Data Submission (Cost; Regulatory Compliance)	Improve the state encounter acceptance rate by improving accuracy, timeliness and completeness of claims data as evidenced by state encounter acceptance rate improving to 95% or above and maintaining this.	QMC Approval: Nov. 2006 Start: Jan. 2007 Other Links:	Manager, Regulatory Compliance	March 2009 And retire	At least annually
Focus Studies					

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
BIB Prenatal Member Incentive Focus Study (clinical outcomes)	Incentive designed to encourage adherence to ACOG CPGs for adequate prenatal care.	QMC Approval: Start: Other Links: HROB DM Task Force; Med Mgt; PAC	Director, QI	May 2009	Annually
Asthma Around the World Focus Study	Asthma incentive designed to increase adherence to NAEPP CPGs for treatment of asthma: PCP visits, fill their med prescriptions, and identify and identify a rescue person.	QMC Approval: Start: Other Links: Asthma Disease Management Task Force; Med Mgt; PAC	Director, QI	May 2009 and PRN	Annually
Practitioner and Provider Network					
Credentialing Committee Reports	Assess number of providers credentialed and recredentialed.	QMC Presentation	Director, Provider Relations	March 2009 July 2009 Sept 2009 Nov 2009	Quarterly
Internal Credentialing Audit Results	Random selection of credentialing & recred files with comparison to URAC & NCQA standards for credentialing.	QMC Presentation	Director, Provider Relations	Sept 2009	Annually
Delegated Credentialing Oversight Audit Results	Complete annual report of all delegated credentialing oversight audits.	QMC Presentation	Director, Provider Relations	July 2009	Annually
Provider Access and	Complete annual results of	QMC Presentation	Director, Provider	July 2009	Annually

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Availability Study results	provider access and availability study.		Relations		
Geo-Access Results/Analysis	Complete annual geo-access analysis for network adequacy.	QMC Presentation	Director, Provider Relations	July 2009	Annually
Significant Network Changes	Complete report detailing significant network changes affecting member access and availability.	QMC Presentation	Director, Provider Relations	March 2009 July 2009	Bi-annually
Open/Closed Panel	Reporting of percent of closed to open PCP panels and analysis of why panels are closed.	QMC Presentation	Director, Provider Relations	July 2009	Annually
Member and Provider Satisfaction					
Member Satisfaction Survey (Regulatory)	Complete Annual CAHPS survey and analysis.	QMC Presentation	Director, QI	Sep 2009	Annually
Member Grievances and Appeals report (Regulatory)	Complete quarterly member grievances and appeals report. Include statistics for turn-around time, overturn rates, and categories trended by type of grievance/appeal.	QMC Presentation Other Links: See G&A PIP above	Director, Appeals & Grievances	Jan 2009 May 2009 Sept 2009 Nov 2009	Quarterly
Customer Service Organization Quality Indicators (Regulatory)	Complete quarterly report for all member service KPIs including calls answered, calls abandoned, and service	QMC Presentation	Manager, CSO	Jan 2009 May 2009 Sept 2009 Nov 2009	Quarterly

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
	levels and claims processing indicators (i.e. TAT, volume, etc.)				
CSO Provider Satisfaction Survey (Regulatory)	Review and analyze results of annual provider satisfaction survey.	QMC Presentation Link to CAHPS Q23 & Q27; Disease management provider surveys	Director, QI ; Manager CSO	July 2009	Annually
Provider Complaints, Grievances, and Appeals (Regulatory)	Complete quarterly report including turn-around times, overturn rates, and categories trended.	QMC Presentation Link to: PIPs 2007- G&A PIP above	Director, Appeals & Grievances	Jan 2009 May 2009 Sept 2009 Nov 2009	Quarterly
Opt Outs from Plan (Increase membership; Regulatory)	Reporting and analysis for trends, interventions, for members who choose to opt out of plan, per MO HealthNet reporting.	QMC Presentation	Director, QI	Jan 2009	Annually
Member and Provider Communications					
Communication Plan and Program Description (Regulatory)	Annual review of communication plan/program description.	QMC Approval	Director, Community Development	Sept 2009	Annually
Provider Communication Materials (Regulatory)	Annual review of provider communication materials (PRG, newsletters, educational mailings, etc.)	QMC presentation (e.g. grid outlining review/changes/additions /deletions)	Director, Provider Relations	July 2009	Annually

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Member Communication Materials (Regulatory)	Annual review of member communication materials (newsletters, handbook, educational mailings, etc.)	QMC presentation (e.g. grid outlining review/changes/additions /deletions)	Manager, Regulatory Compliance	Nov 2009	Annually
Utilization Management					
Productivity Indicators • IP Days/1000 • ALOS • Admits/1000 • Pre-Auth telephone stats • Denial Report • (Costs; Clinical Outcomes; Regulatory)	Review and analyze UM performance indicators for tracking and trending.	QMC Presentation Link to: IRR/Denial PIP	Manager, Health Services	March 2009 May 2009 Sept 2009 Nov 2009	Quarterly
Special Needs & Case Management Activities/Outcomes • Members identified at time of enrollment • Members identified and referred to case mgt • (Regulatory; clinical outcomes; costs)	Review and analyze results of case management activities.	QMC Presentation	Manager, Health Services	March 2009 May 2009 Sept 2009 Nov 2009	Quarterly

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
Pharmacy Utilization Statistics/Outcomes: • Asthma DM fills • Diabetes DM fills • Synagis • Postpartum Depression • Med utilization (Clinical outcomes ; cost)	Review, analyze, and interpret quarterly pharmacy data/outcomes.	QMC Presentation Link to: Asthma Disease Management; Diabetes Disease Management; Synagis and Post Partum Depression PIPs above; Medical Management Committee	Director, Pharmacy	March 2009 May 2009 July 2009 Sept 2009	Quarterly
Clinical and Preventive Care Practice Guidelines (Regulatory)	Annual review of clinical and preventive care guidelines.	QMC Approval	QMC Chair Medical Director	May 2009 and PRN	Annually
Internal Practice Guideline (Technical Recommendations) Review (Regulatory)	Annual and PRN review of new medical technology and review of new uses for current technology.	QMC Approval	QMC Chair Medical Director	Jan 2009 and PRN	Annually
UM Review Criteria - Interqual Criteria Review (Regulatory)	Annual review of Interqual criteria/revisions.	QMC Approval	Manager, Health Services	Jan 2009	Annually
Quality Performance Indicators					
HEDIS (Clinical outcomes; Regulatory)	Prepare detailed report and comparison analysis, with statistical analysis, on each	QMC Presentation	Director, QI	July 2009	Annually

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
	HEDIS indicator.				
EPSDT Program (Clinical Outcomes, Regulatory)	Prepare detailed report of annual EPSDT outcomes.	QMC Presentation	Director, QI	Jan 2009	Annually
Balanced Score Card (Membership, Clinical Outcomes, Cost, Regulatory)	Prepare detailed quarterly report for KPIs for tracking and trending.	QMC Presentation Link to: Medical Management; PAC, Dept. meetings; Corporate DM Calls; MEMC	Director, QI	Jan 2009 Mar 2009 May 2009 July 2009 Sept 2009 Nov 2009	
Adverse Events/ Consumer Safety (Regulatory; clinical outcomes)	Prepare detailed report of the outcomes of investigation of all potential or actual adverse events. • Medical Quality Member Complaints • Adverse Events in claims data • Staff or other verbal report • Member & Fetal Demise reports • Peer Review Committee Activity	QMC Presentation Link to: Peer Review, Credentialing	Vice President, Medical Affairs	March 2009 May 2009 July 2009 Nov 2009	Quarterly
Request to Change Primary Care Provider (PCP) Report (Regulatory;	Prepare detailed report of member's requests to change PCP by reason.	QMC presentation Link to: Provider Relations; Potential Adverse Event reporting and tracking; Complaints,	Director, QI	March 2009 May 2009 Sept 2009 Nov 2009	Quarterly

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
membership)		Grievances and Appeals tracking.			
Miscellaneous					
Fraud and Abuse Program (Regulatory)	Prepare detailed report of fraud and abuse tracking, trending, and analysis.	QMC Presentation Link to: Provider Relations; Credentialing	Manager, Regulatory Compliance	Jan 2009	Annually
Cultural Competency Program (Membership)	Prepare annual detailed report of cultural competence program activities and statistics for employees completing cultural competence program assessment.	QMC Presentation Link to: PAC	Project Team Leader; QI	Jan 2009	Annually
Disease Management Programs					
Asthma Disease Management (Clinical Outcomes; Cost; Regulatory)	Prepare detailed report of outcomes of program.	QMC presentation Link to: PAC; Asthma Incentive above; Medical Management Committee; Pharmacy as noted above	Director, QI	May 2009 Nov 2009	Bi-Annually
Diabetes Disease Management (Clinical Outcomes, Cost; Regulatory)	Prepare detailed report of outcomes of program.	QMC presentation Link to: PAC; Medical Management Committee; Pharmacy as noted above	Director, QI	May 2009 Nov 2009	Bi-Annually
BIB High Risk OB Disease Management	Prepare detailed report of outcomes of program.	QMC Presentation Link to: PAC; BIB	Director, QI	May 2009 Nov 2009	Bi-Annually

Activity (Link to Strategy)	Description	Approving Authority/Committee	Person/Dept Accountable	Due to QMC	Minimum Frequency
(Clinical Outcomes, Cost, Regulatory)		Prenatal Member Incentive above; Medical Management Committee			
Sickle Cell Disease Management Program (2009 start) (Clinical Outcomes, Cost, Regulatory)	Prepare detailed report of outcomes of program.	QMC Presentation Link to: PAC	Director, QI	May 2009 Nov 2009	Bi-Annually

Missouri Care 2009 Work Plan

Appendix B - Missouri Care 2009 Quality Management Work Plan											
Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Complete	Results	Barriers	Recommen-dations
Quality Management Plans & Evaluations											
Annual EQRO Review	Meet standards for external quality review.	Achieve "Met" on all 4 review areas (PIPS; Performance Measures; Compliance with Regulations; Validation of Encounter data)	Submission of relevant documents/on-site review	Elizabeth Opland, Quality Management	07/14/2009 (EQRO onsite review)						
QM Work Plan Evaluation	Evaluate effectiveness of 2008 QM Work Plan	To have completed initiatives on work plan & to have evaluated their effectiveness.	Written presentation of findings.	Elizabeth Opland, Quality Management	12/31/09	Plan will be reviewed & updated quarterly.					
QM Plan	Annually review & revise QM Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management plan.	Written plan.	Elizabeth Opland, Quality Management	11/30/09						
QM Work Plan	Annually review & revise QM Work Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management work plan for 2010.	Written plan.	Elizabeth Opland, Quality Management	10/2/09						
HEDIS Intervention Plan	Based on review of the year's HEDIS results & the effectiveness of the prior year's interventions, revise the HEDIS Intervention plan.	To have a comprehensive plan in place to positively impact HEDIS measures	Project plan.	Elizabeth Opland, Quality Management	12/31/09						
HEDIS Rate Production Plan	Create timeline/project plan for 2010 to complete HMRR data.	All records reviewed	Project plan.	Elizabeth Opland, Quality Management	10/1/09						
Annual Evaluation	Prepare annual evaluation for state in accordance with RFP attachment 6 exhibit 4.	To complete the evaluation by the deadline & to showcase MO Care's activities from the prior year.	Written presentation of findings.	Elizabeth Opland, Quality Management	11/30/09	Evaluation to cover contract year 7/01/08-6/30/09					
HEDIS											
Come in for Care Partnerships (FHC/CHC - WC34 & AWC Outreach)	Improve WC34 and AWC screening rates	WC34 Goal: Reach 65%. AWC Goal: Reach NCQA's 75th%ile of 51.39%, (MO Care current rate is 58.22%)	Follow HEDIS Tech Specs for rate calculation	Quality Management	Bimonthly, 12/31/09	Use HEDIS intervention report monthly to generate mailing to FHC members due for WC34 & AWC services. Letter mailed by MO Care from provider.					
Summer Preschool/Kgarten Well Child Mailing	Improve WC34 rates	WC34 Goal: Reach 65%. (NCQA's H2008 75th%ile is 73.9%, MO Care current rate is 58.22%)	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS Intervention list)	Quality Management	06/15/2009	Use HEDIS intervention report to target all 3-6 years olds without an WC check in the calendar year with a "Summer is a good time to get a check up" flyer.					
AWC Provider Mailings	Improve AWC screening rates	AWC Goal: Reach NCQA's 75th%ile of 51.39%, (MO Care current rate is 49.54%)	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS Intervention list)	Quality Management	08/30/2009	Mail letter with AWC screening guidelines to provider with flyer/chart sticker for members file. Provide teen health brochure for distribution to members. Encourage scheduling AWC at member's next visit.					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Complete	Results	Barriers	Recommen-dations
AWC Teen Health Mailing to Members	Improve Screening rates for AWC, CHL, CCS, flu shots and immunizations	AWC Goal: Reach NCQA's 75th%ile of 51.39%, (MO Care current rate is 49.54%)	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list)	Quality Management	04/30/09, 10/09	Teen brochure mailing					
CHL Provider Roster Mailings	Increase CHL screening rates	Goal to reach NCQA 75%ile of 59.74%	Follow HEDIS Tech Specs for rate calculation (lists generated from monthly HEDIS intervention list)	Quality Management	Quarterly, 12/31/09	Mail PCP list of members needing CHL screening along with stickers to flag member's file.					
Provider Asthma Rosters	Increase ASM rates.	ASM Goal: NCQA 75%ile of 90.74% (Mo Care current rate is 86.96%; state average 87.01%)	Follow HEDIS Tech Specs for rate calculation (rosters generated from internal report)	Quality Management	Quarterly, 12/31/09	Mail member rosters to PCP with members identified as having persistent asthma but who have not had a controller fill. (Include Asthma Action Plan & NAEPP Guidelines)					
Member Asthma Mailing	Increase ASM rates.	ASM Goal: NCQA 75%ile of 90.74% (Mo Care current rate is 86.96%; state average 87.01%)	Follow HEDIS Tech Specs for rate calculation (mailings generated from HEDIS intervention list)	Quality Management	Bimonthly, 12/31/09	Send letter to member encouraging asthma checkup. Include asthma action plan. Will be sent to members on HEDIS intervention list.					
Dental Vendor Monitoring	Increase Dental Rates	ADV combined rate of 30% or state average.	Follow HEDIS Tech Specs for rate calculation	Quality Management/CEO	Quarterly through 12/31/09	Monitor dental vendor for efforts to improve dental screening rates.					
Performance Improvement Projects (PIPs)											
EPSDT PIP (new for 2009)	Increase EPSDT rates in children 7 to 11 years	Goal: 50% of children in this age group	Follow HEDIS Tech Specs for rate calculation	Quality Management	Quarterly, through 12/31/09	Provider Rosters of members due for a well-care visit during members' birthday month					
Lead Screening in Children (new for 2009)	Increase lead testing rates	Lead Goal: to reach 75%. (MO Care current rate is 71.43%).	Follow HEDIS Tech Specs for rate calculation	Quality Management	Ongoing through 12/31/09	Provider and member mailings, Lead screen brochure, Provider Toolkit					
Asthma Management	Increase the number of members with persistent asthma who are being prescribed controller meds.	ASM Goal: NCQA 75%ile of 90.74% (MO Care current rate is 86.96%; state average 87.01%)	Follow HEDIS Tech Specs for rate calculation	Quality Management/ Medical Management/CMO	Quarterly through 12/31/09	Provider Rosters; member mailing; follow up by CR nurse after member discharged from hospital stay with asthma. CMO education of PCP when member hospitalized for asthma.					
Adolescent Well-Care	Part of a State Wide PIP to increase MO rates on HEDIS AWC measure.	State's goal is to raise the statewide average on this measure. Missouri Care's goal is to attain NCQA's 75th%ile of 51.39%%.	Follow HEDIS Tech Specs for rate calculation	Quality Management	Ongoing through 12/31/09	Provider Rosters – September 2008; member mailing in July 2008 (expansion county members) and November 2008 (intervention list)					
Chlamydia Screening	Increase the number of members aged 16 to 24 who are screened for chlamydia	Goal to reach NCQA 75%ile of 59.74%	Follow HEDIS Tech Specs for rate calculation	Quality Management	Quarterly (March, June, Sept, Dec 09)	Provider Rosters, Teen Well-Child Mailing (parents of 12-14 year-olds), CCS/CHL birthday cards					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Complete	Results	Barriers	Recommen-dations
Well-Child 34 /WIC Collaboration	Raise HEDIS Well-Child 2 rates by collaborating with local WIC agencies.	WC34 Goal: Reach 65%. (NCQA's H2008 75th%ile is 73.9%, MO Care current rate is 58.22%)	Follow HEDIS Tech Specs for rate calculation (list generated from HEDIS intervention list or internal report)	Quality Management	Ongoing in 2009	Identify MO Care WIC participants. Notify WIC of members age 6 months-4 years due for Well-Child Check. WIC then encourages member to seek appointment. MO Care in turn encourages members who do not participate in WIC to sign-up.					
Mental Health Follow Up	Increase # of members receiving 7 & 30 day follow up appointments following discharge from inpatient stay for mental health.	HEDIS 7 day f/u 36.52%; 30 day 67.78%	Follow HEDIS Tech Specs for rate calculation (intervention based on inpatient census)	Behavioral Health	Ongoing through 12/31/09	Care manager works with inpatient facility to schedule follow up appt. Case manager works with member to ensure member keeps appointment and can get to appointment. BH manager monitors compliance of inpatient facilities in scheduling f/u appointments. Develop exclusion database.					
ER Utilization	Reduce ER utilization by individuals with 10 or more inappropriate visits in a year and reduce use of ER for minor illnesses. This will reduce health plan cost and increase the quality of care to the member if they establish a medical home rather than using the ER.	Significant decrease in # of individuals with 10 or more inappropriate visits in a year. Decrease in % of inappropriate visits compared to total visits to ER.	Will use PPM and internally pulled report to measure indicators. Data tracked monthly.	Quality Management/ Medical Management;Member Services/CMO	Monthly	Details TBD. Members with >2 ER visit for a non-emergent diagnosis will be sent a letter reminding them to use their PCP & describing proper use of ER. Members who continue to frequent the ER after the letter will receive a phone call. Individuals with 10 or more inappropriate visits will be targeted through case management and CMO working with members PCPs.					
Polypharmacy Project (BH/MH collaborative) (new for 2009)	Track and reduce the potential for inappropriate and unsafe medication combinations.	TBD	A collaboration with the health plan and the corporate pharmacy whereby a quarterly file is sent to the plan with members who have received more than 50 perscriptions over the previous 6 months.	Dr. Lacey, Melody Dowling, Brenda Moore, Dr. Matera	Ongoing, 12/31/09	Members are contacted to confirm medical home PCP assignment and to assist in coordinating services by the case manager. The provider is then sent a letter with the plan's analysis or contacted by phone. Utilization patterns will be tracked to see the impact of this project and the member will be followed by case managers.					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Complete	Results	Barriers	Recommen- dations
Impactable Admissions Project	Reduce ER utilization by 2.5% for members with co-occuring substance abuse/MH and physical conditions	Reduce ER use by 2.5%	TBD	Dr. Lacey, Melody Dowling, Brenda Moore,, Dr. Matera	Ongoing, 12/31/09	Enroll members in an integrated case management program. Case manage for members with 10 or more ER visits in the past 12 months					
Prevention & Wellness											
EPSDT Postcards	Increase the # of children receiving annual EPSDT exams & staying up-to-date on imms.	Maintain WC1 rate of 62.27%; Increase WC 2 rate to 70.80%; Increase AWC rate to 47.90%; and Increase EPSDT participation to 72.35%.	See HEDIS measures for childhood imms; adolescent imms; well child 1, well child 2, & adolescent wellcare. Increase EPSDT on 416 & reduction of state sanction.	Quality Management	Monthly	Mail postcards to members during their birth month to remind them to receive their EPSDTs and stay up to date on imms. Other developmental info included on cards.					
Preventive Care Toolkits	Increase provider compliance with EPSDT, Imms, & Lead Guidelines	Improved performance on HEDIS measures of WC2, AWC, CIS, & AIC. Increased lead testing rate of 1 & 2 year old children.	HEDIS Tech Spec for HEDIS measures. Lead rates generated by internal report. Provider satisfaction with toolkit also evaluated.	Quality Management	Ongoing	Preventive Care Toolkits delivered to provider offices. Toolkits include overview, guidelines, required, and recommended forms on EPSDT, LEAD, and imms. Toolkits presented to office managers and clinical staff.					
Cervical Cancer Screening Birthday Cards	Maintain CCS rates and increase CHL rates.	Goal to reach NCQA 75%ile of 76.35%; Increase CHL overall rate to 58.2%	Follow HEDIS Tech Specs for rate calculation (list comes from monthly on demand report)	Quality Management	Monthly, 12/31/09	Mail women a CCS card reminder during their birth months (monthly)					
On-hold messages	Prevention & wellness topics	Increased awareness by member of P&W topics.	Topics of messages are tracked to insure a variety of messages as well as key topics are included regularly.	Quality Management	Quarterly	Update on hold messages with relevant and seasonally appropriate prevention & wellness topics.					
Education through Provider, Member, & School Nurse Newsletters.	Prevention & wellness topics	Increased awareness by members and providers of P&W topics.	P&W articles are tracked to make sure all HEDIS topics are covered annually and seasonal topics are covered as appropriate (e.g. flu shot)	Marketing (All Dept. contribute articles); QM & MM responsible health ed materials	Quarterly	Prevention & wellness articles in every issue.					
Health Education materials distributed at community events	Prevention & wellness topics	Increased awareness of community of P&W topics.	# of events attended and # of attendees are tracked.	Marketing – identifies events; QM orders & selects health ed materials.	Ongoing	Prevention & wellness materials distributed at community events such as health & back-to- school fairs.					
Member services outreach calls	Educate members on appropriate preventive services based on age.	Improved EPSDT and HEDIS performance on WC1, WC2, AWC, AIS, CIS, CCS, and PPC.	# of calls are captured through call tracking by HEDIS category.	Member Services	Ongoing	Information on preventive services is included in new member call scripts.					
Pregnancy Packet Mailing	Educate members on issues related to pregnancy (e.g. prenatal care; delivery; nutrition)	Packet sent to all pregnant members.	# sent per month is tracked.	Case Management	Ongoing	All identified pregnant members are mailed a pregnancy packet including a Pregnancy Book.					
Post Partum Mailing	Educate members on importance of postpartum care & on caring for new baby.	Packet sent to all moms who deliver.	# sent per month is tracked.	Case Management	Ongoing	New mothers are sent the "You and Your Baby Booklet". Well- child checkup and imms schedules are included.					

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Committee Approval Dates	% Complete	Results	Barriers	Recommen-dations
Did Not Keep Appointment Initiative	Educate parents on importance of keeping well child and immunization appointments.	Improve EPSDT and HEDIS performance on WC1, WC2, AWC, & CIS.	Track % of members receiving a well child visit following DNKA letter or phone call.	Quality Management	Ongoing	Providers notify MO Care when am member does not show for a well child visit. Parent is sent a letter on importance of visits & of keeping appointments. When a 2nd notice is received, QM Nurse contacts parent to discuss barriers to care.					
Credentialing											
Ongoing monitoring of providers.	To monitor providers for licensure sanctions & complaints between recredentialing cycles.	Identify all providers with sanctions & quality issues & to bring them back before the MQM committee if necessary.	Ongoing monitoring activities logged monthly.	Christina Schmidl	Monthly	Review: OIG exclusions report; Healing Arts Newsletter (semi-annually); call tracking report; sentinel/adverse events.					
Credentialing/Recredentialing	Receive application & supporting documents & complete primary source verification following NCQA guidelines.	Meet 180 day NCQA guidelines for primary source verification. Recredential all providers every 3 years.	# of providers initial credentialed; # of providers recredentialed. Track # of providers with expired credentials.	Christina Schmidl	Ongoing						
Delegated Credentialing Audits	Complete audits of all delegated credentialing organizations.	Audit 100% of delegated providers annually.	% of delegated providers audited.	Christina Schmidl	Within 1 year of prior audit (date varies by organization) – all to be completed by 12/31/09						
Service Performance Indicators											
Provider Access Survey	Determine if appointment access standards are being met.	100% of providers surveyed will meet access standards.	Telephone Survey	Michael Dunne	09/01/2009						
Member Satisfaction Survey	Monitor Member Satisfaction with Missouri Care & Network	Perform at or above last year's measures and the national benchmarks.	Member Survey administered by the Myers Group.	Debby Langley / Elizabeth Opland / Corporate	06/01/2009						
Provider Satisfaction Survey	Monitor Provider Satisfaction with Missouri Care	Maintain peformance.	Survey administered by the Myers Group	Michael Dunne / Elizabeth Opland / Corporate	07/01/2009						
Monitor member/provider grievances & appeals	Maintain quality services for members; address member concerns.	All grievances are addressed & closed.	Assignment to appropriate manager for resolution through SIC committee.	Debby Langley / SIC Committee	Ongoing						
Monitoring of sentinel events/quality issues.	Maintain quality care by evaluating sentinel events & quality issues.	Evaluate all sentinel events & quality concerns to determine if corrective action is needed.	All events are logged and tracked/trended. Potential quality of care issues are presented to MQM.	Brenda Moore	Ongoing						

Molina Healthcare of Missouri
Work Plan for SFY 2009

In order to enable MHMO's Quality department to focus more effectively on opportunities for improvement, MHMO is increasing the staffing level in the Quality department. MHMO is actively recruiting a HEDIS specialist who will perform audits and data analysis of HEDIS reporting as well as documentation of findings.

Through strategic planning, MHMO is committed to increasing targeted 2009 HEDIS scores through a combination of improved encounter data capture, reporting and member/provider incentives. MHMO plans to focus on the following HEDIS measures: Adolescent Immunizations and Well Care Visits, Cervical Cancer Screening, Childhood Immunizations, Timeliness of Prenatal Care and Asthma Medication use. In addition, MHMO will focus on the following CAHPS scores: Health Plan Overall, Health Care Overall and Health Plan Complaint and Problem Resolution.

MHMO will continue to participate in the State-wide PIP for increasing the rate of adolescent well care visits. MHMO will also focus on continuing the Early Intervention in Prenatal Case Management and the Relationship to Very Low birth Weight Babies PIP as well as identifying members who are at risk for developing post-partum wound infection PIP.

MHMO will continue to facilitate organizational efforts to achieve State and local regulatory compliance and NCQA Accreditation in 2011.